

## **Deep End Report 11**

### **Alcohol problems in adults under 40**

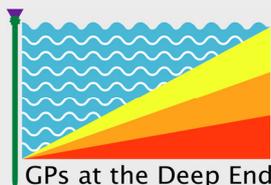
*The eleventh meeting of "General  
Practitioners at the Deep End"*

27 August 2010

***Fourteen Deep End GPs and 16 alcohol professionals from Glasgow and Edinburgh met on Friday 26 August 2010 at the Teacher Building, St Enoch Square, Glasgow, for a discussion about policies and practices for adults under 40 with alcohol problems.***

## **SUMMARY**

- Alcohol misuse in young adults is a huge problem which needs to be addressed at many levels. This meeting focused mainly on the contributions of general practice and community addiction services, with additional inputs from the acute and voluntary sectors and from public health practitioners.
- The NHS allocates fewer resources than might be expected to address alcohol problems, given their impact on individuals, families, the NHS and the economy.
- For people needing help there are many possible entry points to the system. There needs to be clarity about the paths they may then follow.
- Pathways are important for planning, integrating and evaluating services, but people with alcohol problems often lead chaotic lives, so there is also a need for continuity and flexibility based on ongoing relationships with professionals whom they know and trust.
- Effective links between services are the key to integrated care. General practices and community addiction services should actively review their links in terms of professional relationships, communications and record of joint working.
- Shared information concerning the progress of patients through systems is also essential, and can be helped by improvements in IT, although there are issues concerning confidentiality (whether people are content to have their personal information shared) and professional engagement (general practitioners vary in how they respond to information communicated from third parties).
- Community addiction teams also vary in what they do and how, but have developed a range of innovative services, some of which are not well known to GPs.
- The caseload of CATs in Glasgow is thought to cover about 40% of people with major alcohol problems, which leaves about 60% using other services, including general practice.
- The role of GPs is to assess risk, provide brief interventions, minimize harm, manage physical problems and co-morbidity and act as a signpost to other NHS, local authority and voluntary services.
- It is not clear whose role it is to provide practices with bespoke information on the range of services in their area.
- Current and future NHS staff need more education and training on alcohol and addiction issues at undergraduate, postgraduate and continuing professional levels.
- Professional experience of working on the front line is an important source of evidence to inform advocacy. Practitioners need to find their collective voice in this respect
- The meeting raised many unanswered questions including the effectiveness of brief interventions in young adults, and arrangements for detoxification, joint working, sharing information and practice-attached alcohol workers.
- The meeting demonstrated the value of the exchange of views and experience between professionals and between services, as the first step in developing a more integrated care system for young people with alcohol problems.



*“General Practitioners at the Deep End” work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Section of General Practice & Primary Care at the University of Glasgow.*

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## About this report

The aim of this report, which is based on reports by a team of rapporteurs, is to summarise the main views expressed at the meeting in order to inform and enable subsequent developments in policy and practice. It is not expected that everyone attending the meeting will agree with everything in the report. Inevitably, given the geographical concentration of Deep End practices in Glasgow, the meeting often referred to the local Glasgow context, including Community Addiction Teams, which do not exist in other parts of Scotland.

## Abbreviations

- **AA** Alcohol Anonymous
- **CAT** Community Addiction Team
- **CBT** Cognitive Behavioural Therapy
- **Detox** Detoxification
- **FAST** Fast Alcohol Screening Tool
- **GCA** Glasgow Council on Alcohol
- **HEAT** Health, Efficiency, Access and Treatment
- **LES** Local Enhanced Service (additional, voluntary contract for GPs)

# PARTICIPANTS

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| <b>Linda De Caestecker</b> | Director of Public Health, GGC (session 4 only)                 |
| <b>Graham Watt</b>         | Professor of General Practice/Co-organiser of the meeting       |
| <b>Sakeet Priyadarshi</b>  | Lead Clinician, GGC Addictions Partnership and co-organiser     |
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# INTRODUCTION THE SIZE AND RANGE OF THE PROBLEM (Saket Priyadarshi)

- Although average alcohol consumption per head in the UK is less than in some other EU countries, it is rising.
- Average consumption has returned to the very high levels observed at the end of the 19th century, and is now about twice the level recorded between 1930 and 1950.
- Beer consumption comprises about half of the current total, and has remained steady for over 30 years.
- There have recently been large increases in the consumption of wine and spirits.
- Alcohol-related mortality doubled in Scottish men in the ten years to 2006 and is over twice the level recorded in England or Wales.
- Alcohol-related mortality in Scottish women is similar to that in English men and almost twice that recorded in women in England, Wales and Northern Ireland.
- Mortality rates from alcoholic liver disease have risen by over 50% in Scottish men and women since 1998.
- Half of Scottish men and over a third of Scottish women exceed the recommended daily limits of alcohol consumption.
- Emergency departments in Scotland deal with over 70 alcohol-related assaults every day.
- One in six road deaths in Scotland is caused by drink driving.
- Alcohol is a contributory factor in over half of deaths in fires in Scotland.
- 65,000 Scottish children are estimated to live with a parent whose drinking is problematic.
- Between 1998 and 2003 there was an 11% increase in the numbers of men and women consulting their GP with an alcohol problem.
- In 2009/2010, there were 2996 acute alcohol referrals and 639 alcohol admissions for a planned detoxification to hospitals in Glasgow.
- Alcohol-related mortality is steeply socially-patterned, with rates five times higher in deprivation category 5 (most deprived) compared with deprivation category 1 (most affluent).

## Suggested reading

- *Changing Scotland's Relationship with Alcohol: A Framework for Action* Scottish Health Action on Alcohol Problems [www.shaap.org.uk](http://www.shaap.org.uk)

# SESSION 1 WHAT CAN BE DONE TO IDENTIFY AND HELP PROBLEM DRINKERS?

## Problems can present to general practice in at least five ways

- Self presenting (this tends to be by older patients).
- A family member expressing concern (e.g. mum worried about child, needs family doctor approach in order to establish relationships with the family).
- Screening using validated screening tools (anticipatory care e.g. Keep Well).
- Case-finding, when patients present with other problems e.g. depression, or women attending for contraceptive care.
- Referrals from A&E and minor injuries units (considered higher risk patients).

These types of presentation were each discussed.

- Some patients don't want their GP to know and will go to voluntary services instead.
- Teenagers were thought to engage with other parts of health service – and not GPs.
- Patients are encouraged to go to the Sandyford clinic for sexual health matters, and to obtain the morning-after pill from chemists – both lost opportunities for GPs to develop relationships with young people.
- Voluntary self assessment can occur opportunistically e.g. at sexual health clinics.
- A range of services (e.g. Sandyford/voluntary sector/pharmacy/police) can apply a screening approach, calculating FAST scores.
- Questions then arise, however, as to whether patients are willing for such information to be passed to their GP, and whether GPs are keen to receive and act on such information.
- GPs are not convinced it is helpful to be informed if a patient is found to be a problem drinker elsewhere. How should GPs respond? Possibly ask the patient to attend to discuss, or document for it to be discussed at next attendance – there was no agreement on what to do.
- If there is time at end of a consultation, GPs tend to prioritise smoking cessation advice, possibly because of contract incentives, or the speed and ease of smoking advice, compared with the time needed to explore alcohol problems and motivation.

## Loss of contact with young mums/teenagers

- GPs expressed concern at their loss of contact with younger people through their lack of involvement in antenatal care.
- Maternity services screen women but don't inform GPs of the results.
- Communication from midwives was said to be poor.
- GPs reported variable levels of communication with health visitors – some excellent, with informal discussions with GPs about possible problem drinkers.

## Contacting young males

- Young men don't attend their GP, especially about alcohol problems. If they do, their mother is often present.
- The voluntary sector has workers going into schools – the worker needs to have a youth element, e.g. male students, who may be seen as role models, but they don't stay long term as they finish their studies and move on.
- GPs were not aware that there is a member of staff within Community Addiction Teams (CATs) whose role is to work with the 12 to 21 age group.
- CAT and voluntary sector seem to be very proactive with this age group – chasing them up with texts etc.
- Voluntary sector and young CAT workers use internet resources (e.g. online self assessments/use of support networks etc).
- GPs are not best placed to set up this type of service, whereas CAT workers in the NE CAT go into schools, holding educational meetings with new foster parents etc, but this is only on request and is not part of their routine.

## Ways of engaging young people

- GPs are seen as too authoritarian to be involved with this age group – too much like teachers.
- Posters in waiting room/in toilets.
- Literature should be appropriate for young people. The problem is that young people don't attend their GP. Perhaps parents will pick up such material and take it home?
- Messages must be made more appealing e.g. how to stay safe, combining information about sex/alcohol/drugs together.
- Information screens in health centres were thought to be more appealing.
- Engage with parents. There was concern that parents buy drink for young people, as they feel it is safer for them to be drinking in their house, rather than risk them going out and taking drugs etc. Parents need to be guided that this is not helpful. Some parents 'complain' if their teenager doesn't drink as this may be seen as odd behaviour.
- Communication problems are compounded by parents who don't realise that their own consumption is over recommended limits.
- Older kids talking to younger kids helps.

## Comments on consultations

- In consultations – a good history is non-judgmental; be supportive and congratulate them for seeking help; give brief intervention; check LFTs. Avoid medication. Follow your nose and ask if you smell alcohol! Use a fit note to bring them back for review.
- Referring to a sensible limit rather than recommended limits may be more sensitive.
- GPs sometimes don't know themselves what a unit is.
- Moving away from the word 'binge' – telling patients that >2 pints a night is a binge doesn't go down well.
- Patients may say they will reduce their intake, but still think that 'getting hammered' on a Friday/Saturday night is acceptable.

- Smoking cessation advice is easier as abstinence is the message. Trying to discuss 'moderation' is much harder and more time consuming.
- Avoid language which might frighten or put patients off. Use of the word 'risky', rather than 'harmful' is felt to allow patients to relate their own intake to their own health.
- The ramifications of labelling are thought to be a big issue, especially for those drinking a bit too much every night of the week (i.e. not addicted as such, but drinking too much) and concerned about this being known by employers or insurance companies.

## Brief interventions

**NOTE** Based on SIGN Guideline 74, the Scottish Government introduced the HEAT 4 target requiring Health Boards to deliver 149,449 alcohol brief interventions over a three year period (35,000 in Glasgow), with primary care, antenatal care and A&E as the priority settings. Patients who attend with a potentially alcohol-related problem are screened by GPs, midwives or hospital doctors. Those screening positive are then offered a short, structured, motivational interview, suitable for anyone who is regularly drinking over recommended limits but who is not alcohol dependent.

- GPs are lukewarm in their enthusiasm for this scheme, despite financial incentives. The screening component has proved more acceptable than the brief intervention component.
- Although the test is FAST to perform, it results in a large number of patients with a score greater than 2 (within the range 0 to 16), which is considered "a hazardous drinking score".
- Adding a few minutes to large numbers of consultations in general practice in deprived areas, where workload pressures are high, is problematic, and compounded by professional uncertainty about the effectiveness of these additional minutes, usually at the end of a consultation.
- There is also uncertainty about which member of the general practice team is best placed and equipped to deliver such advice.
- Do brief interventions work in young people? The Cochrane review of secondary care did not find positive results. Should brief interventions continue in primary care?
- Early intervention (e.g. after hospital admission) was considered to have some impact but there is a lack of evidence concerning the efficiency of brief interventions. A two-year follow up is in progress of a cohort of attendees at GG&C Minor Injuries Unit who have received a brief intervention.

## Social context

- In deprived areas alcohol is often one of many health and social issues and not always the patient's first concern.
- Patients use alcohol as an escape – it might be the only thing they have to look forward to.
- There is a need to increase public and professional knowledge about alcohol units and levels of safe drinking.
- There is also a need for consistency in advice across and within professional groups.

- Patients with risk factors (poverty/deprivation) are known by GPs from an early age, but early targeted prevention requires a multi-agency approach including schools.
- GPs need to explore links between presenting mental health issues and alcohol and to treat the alcohol problem before depression/anxiety. Again, the evidence base for intervention is poor, partly due to the time required to build motivation.

## **Long term issues**

- The separation of psychiatry and addiction services in secondary care can lead to problems when trying to provide integrated primary care for individuals living in the community.
- The real challenge lies in helping patients to remain sober, which requires resources to address the removal of social networks and recognition that managing alcohol addiction is a social rather than a medical problem.
- The role of the medical profession is to work with other agencies but communication between services is variable.
- Addiction services have to balance what can be done for individual patients with the needs of the large number of people needing their services.

## **Contract and screening issues**

- FAST scores don't always target the right group. There is a gap between problem drinkers and dependent drinkers.
- The GP contract does not focus on alcohol, the priority being smoking. There were mixed views about the Local Enhanced Service (LES) for alcohol problems, with concerns about uptake, sustainability and what a GP can actually do.
- Screening can be useful, in helping an individual to accept that he has a problem, but it is then up to the patient to follow this up.

## SESSION 2 WHAT CAN GENERAL PRACTICE OFFER YOUNG ADULTS WITH ALCOHOL DEPENDENCE?

This session considered treatment options in general practice and the indications for referral to other services.

GPs vary between those who consider themselves primarily as a signpost to other services and those prepared to take a more active role in addressing patients' alcohol problems.

### Treatment

- Two types of patients were identified – those who want help and those who do not.
- Risks need to be stratified, on the basis of patients with co-morbidity, with possible unidentified co-morbidity and without co-morbidity.
- GP practice-based treatment should focus on minimising harm (by relapse prevention, brief intervention, motivational interviewing over a series of consultations) and maximising chances (keep to referral pathway, general health promotion, diet, blood screens etc).
- GPs also have a coordinating role in the management of physical conditions and co-morbidity.
- Referral to counselling services, wherever available (sometimes available in practice, or GCA – see below).
- Inpatient detox is indicated if the patient is unwell, but there is a long waiting list.
- Advise about AA, which is often overlooked, but AA works well for some patients
- Some prefer services that can look into social circumstances. It was recognized that AA can be good for vulnerable patients.
- Not all GPs are motivated to address alcohol detoxification, and some are not aware of alternatives to Librium as the drug of choice.
- GPs have different thresholds for their decisions to offer Librium detoxification.
- Consistency of approach within practices is considered important.

**NOTE** *The Glasgow Council on Alcohol (GCA) is a charity which works in deprived areas of Glasgow, provides counselling, work with schools, feedback to health board and addiction services. ALISS (Alcohol Intervention and Support Services) is a new GCA service, funded by NHS GG&C and Glasgow Addiction Services, which has been developed to tackle harmful drinking, offering up to 12 sessions of counselling, starting within three weeks of referral. People may be referred by any agency, following FAST screening, a brief intervention or by self-referral).*

### Community Addiction Services

Alcohol workers aim to:

- Look for a 'solution' rather than a 'problem'.
- Get patients to understand their current problem and set future goals.
- Be motivational.

- Seek to approach goals rather than use avoidance.
- Reduce alcohol rather than stop.
- Explore relationships.
- Build up a relationship with patient and establish trust.

GP knowledge and views of CATs were variable:

- There is a perception that people addicted to opiates are given priority by CATs.
- Patients are often not keen on attending services with other substance abusers.
- Some GPs are not aware that there are alcohol specific workers in CATs in Glasgow and do not refer patients to CATs to them because of the stigma of association with drug misuse.
- It was said that GPs would only refer patients to CATs if they were young and male.
- Many Glasgow GPs are unaware of the possibility of self referral by patients to CATs.
- CATs also allow drop-in access, which can be arranged over the phone, and is helped when GPs phone beforehand and can tell the patient the name of the person at reception who expects them.
- There is a lack of evidence base to support referral decisions for alcohol detoxification.
- Evidence is needed to determine the efficacy of GP detox versus CAT detox, although this is problematic as like may not be compared with like. GP detox tends to be chaotic, in response to urgent demand because of related family crises or imminent court appearance, whereas the waiting list for CAT detox may serve as a filter and capture more motivated patients.
- The outcome of interventions should be measured on a continuum from reducing harm to sobriety.
- Drug services are better resourced than alcohol services even though referral rates are 1:3 respectively.
- It was said that new funding would mean equity between alcohol and drug services.

## **Communication between services**

- Communication is the key, with insufficient linking between all agencies. Since the West CHCP was established, GPs had received no communication from the CAT about whether patients have been detoxed or had even attended.
- A system was described with an alcohol key worker based in the GP surgery. This had worked very well, but depended on individuals, and if they leave it can all fall apart.
- The CAT in North East Glasgow is well thought of by GPs and patients. Not so in other CATs, where the service is considered poor and patients/GPs tend to refer to the voluntary sector.
- In Lothian, each practice has a CPN attached who is aware of local statutory services – but not voluntary services.

## Acute hospital care

- Patients often end up in hospital (seizure, head injury etc), but if 50% of people are drinking more than recommended, hospital contacts can only address a small part of the overall problem.
- Glasgow GPs report that FAST scores are not fed back to them from hospital as happens elsewhere.
- There were mixed views on whether GPs should act on A&E discharge letters e.g. if it mentions head injury and alcohol, how far should the GP go to look into it, or is it enough for patient in A&E to be told to see GP. In Lothian, patients are given their results and feedback in A&E and told to see their GP.

## Other issues

- 40-70% DNA rates reported by liver clinics.
- Separation of alcohol issues in psychiatry training and in liver training is not considered helpful. There is a need to increase alcohol and poly substance abuse in the training of all professional groups.
- Previous alcohol abusers (i.e. reformed alcoholics) can help motivate clients.
- Do GPs 'sit' on information about young alcoholics (e.g. from family members) but not take any action? Confidentiality issues.
- Patients are often hard to engage and have high attendance at A&E, using many services but engaging with none.
- Patients who have had multiple detoxes are difficult to manage.
- Maintenance is harder to manage than detox.
- Young patients often can't visualise future goals.
- 'End stage' patients are often too late to save.
- Normalisation of drinking with our culture – 'everyone does it'.
- Low levels of employment in deprived areas – CAT can refer to employment services.
- Job Centre Plus has a specialist service for those with previous alcohol addiction.

A related issue is sensitivity to the use of language and written text in objectifying what it is that is to be done. For example, participants referred to how negative patient signifiers were born in medical notes and could take on an existence of their own thereafter: the consultant's initial entry of the 'alcoholic experiencing seizures', as opposed to 'Mr Smith experiencing alcohol related seizures', repeated ad infinitum by other clinical staff, continuing a stigmatising process that is ultimately realised and exchanged at the interface between patients and other services.

It was noted that with a caseload of 12,000 people, CATs in Glasgow are in contact with about 40% of people with alcohol problems. The average caseload is about 60 cases per alcohol practitioner. The other 60% are managing on their own or with other services, including general practice. CATs could not cope with a much larger caseload, raising the question of what services are needed to meet the needs of people who are not in contact with CATs. Problems often come back to the GP as a last resort.

## What leads to success?

- The timing of interventions is important.
- Substituting another activity – e.g. Outward Bound, drama, boxing – can take the place of alcohol.
- More outpatient detox should be available.
- Inpatient detox is needed when there is no social support.
- Need to help with social difficulties – often the root of the problem.
- Services must be accessible, which for some patients is best served by having a counsellor available in the practice.
- Patients often can't leave their 'territory', which puts a premium on services being available locally.
- GPs felt they would like to introduce a patient to a counsellor. But when would they be available and would practices have space?
- It was noted that patients have to be literate for CBT to be effective.
- Other community venues may be an option e.g. health improvement premises, sexual health clinics, housing association clinics, diabetes clinics.
- Both general practices and CATs work best with stable workforces, building up contacts, relationships, knowledge and expertise over time.

## **SESSION 3 WHAT ARE THE BEST ARRANGEMENTS FOR JOINT WORKING?**

The meeting exposed several examples of potentially fragmented care based on inadequate communication:

- GPs did not know that patients could self-refer to CATs, or that CATs have staff working exclusively with people with alcohol problems in the 12 to 21 year age group
- GPs were unaware of the opening of a new residential alcohol treatment centre in their CHCP area.
- A GP and an alcohol liaison nurse, working in the same area, met each other for the first time at the meeting.
- The general problem of knowing what services are available in a locality at a particular point in time, and how they may be accessed.

Three important types of shared information were identified:

- A list of resources available within a locality, including how and when to make contact.
- Descriptions of the pathways along which patients/clients could travel, from different starting points.
- Tracking information, keeping relevant professionals up to date with a person's progress in the system.

Each type of information raises separate issues concerning how such information should be collated and made available to others, whether and in what form the information can be processed (overcoming practical issues of IT and ethical issues of confidentiality) and whose responsibility it is to maintain the information system.

There is a general lack of knowledge of resources and services available locally. GPs are well placed to make use of such information in directing patients to services outside the practice. A good example is the work of the Glasgow Council on Alcohol (see above). Much of the necessary information exists but has not been communicated successfully. Is it the responsibility of CATs, or the voluntary sector, or someone else, to inform GPs about what is available locally?

There is no 'shared care' for alcohol problems, as there is with methadone clinics, partly due to the lack of protocols and methods for sharing information.

IT systems (e.g. the clinical portal) allow staff in A&E to see information about previous visits, which is very helpful, but ideally such systems would be merged with primary care and alcohol services for better continuity and co-ordination between services. Confidentiality is a key issue. When patients join CAT they sign a disclosure for CAT to share relevant info with other services. Should GP practices do this?

It is important to avoid the stop-go nature of short term initiatives. Integrated services need time:

- To establish effective systems of working.
- To build and sustain shared knowledge of how the system works.

- To develop and sustain the professional relationships on which each step of the system depends.
- To build a culture of integrated care, based on shared knowledge and experience.
- To avoid the disruption and inefficiency of discontinuity.

Effective referral arrangements are helped when:

- Referral is between professionals who know each other and have developed a positive working relationship, based on mutual understanding of their roles and circumstances.
- Referral is to a familiar and accessible location.
- Referral can happen quickly.
- The referral is personalized (e.g. with a link worker to show the way, or by prior contact with the person at reception).
- Feedback is provided promptly.
- Services are established with ways of working that are consistent, and complementary to each other.

The case was made for practice-based “alcohol liaison officers” to personalise the service and in recognition that patient motivation may be transient, so that there is a need to engage quickly to reduce harm.

It was noted that different services could have different aims and that what appeared as a success in one area might not be recognized as such in another.

Services can also vary according to the type of population they serve – the social homogeneity of the east of Glasgow possibly being an easier setting in which to develop a coherent service than the social heterogeneity of the west of Glasgow.

It was recognized, however, that successful joint working between services depends on local leadership and the extent to which joint working is prioritized within each service.

Contrasting arrangements were noted between Glasgow and Edinburgh, with integrated community addiction services in the former and separate alcohol and drug services in the latter. A positive aspect of Edinburgh’s separate alcohol service is the role of the Community Psychiatric Nurse (CPN), with specialized knowledge and close working links with GPs.

These differences highlighted the value of opportunities to compare and contrast the views and experience of professionals working in different systems, so that effective practice can be shared.

## Suggestions

- More alcohol services, more staff.
- More flexible arrangements e.g. go to where the patients are.
- Better advertising, for GP and self referral.
- Standardised service agreements.
- Alcohol worker allocated to a practice.

## **Alcohol workers attached to general practices**

There was much discussion of this proposal, suggested by GPs to increase the resources available to them to help patients with alcohol problems, including making better use of other services, facilitating referral.

CATs managers felt they couldn't justify this use of resources, given the large number of practices, the variable need and demand within practices and the uncertainty about how busy such workers would be.

It was pointed out that GPs could make better use of CATs, which are more accessible than some GPs think.

On the other hand, CATs do not have the capacity to take on large numbers of extra clients, leaving general practices to cope.

A range of possibilities was proposed including an alcohol liaison nurse attached to a practice, a "care co-ordinator" post or a "GP attached alcohol worker". In each case, the key element would be that the person would be known to the practice and would develop a regular working relationship.

If such posts could be established and evaluated, a practical problem in very deprived practices, which most need such support, is the lack of space to accommodate the work.

The location of service provision was also seen as potentially problematic, given the non-geographical nature of some GP lists and the geographical nature of much community-based work. On the other hand, frontline staff and frontline knowledge were seen as where the process of joint working begins.

## **Staff development**

Training and awareness of alcohol issues were seen as important for all staff employed in a face to face capacity, including reception staff and practice managers, given that all are in a position to acquire and share information about alcohol problems.

Another issue related to joint working, on which there was disagreement, was related to the expectations and capacity of GPs to provide particular therapies. On the one hand, some GPs saw the limits of their role in engaging with other services through referral schemes, for example, counselling services; while on the other, some GPs saw the consultation as an opportunity to address alcohol problems by building on existing relationships. Short training sessions for staff were suggested as a way of enhancing the counselling skills already employed. This was seen as a way of increasing the awareness of patients who really do need referral for existing drinking or who have the potential to move on to more harmful drinking.

It was suggested that GPs should get appraisal points for going out and meeting face to face the community teams to whom they refer patients.

## **Alcohol service resource group**

Another suggestion to improve joint working amongst agencies was the development of an alcohol service resource group; a regular, multidisciplinary meeting attended by representatives of interested parties who could feedback on

strategies and local resources. It was suggested that a GP attached alcohol worker might be a useful way of plugging into this network.

Attitudes of health practitioners towards alcoholism and problem drinking were identified as often being mired in a particular moralistic outlook, described by one participant as a form of class antagonism. Training and the promotion of 'reflective' practitioners were suggested as ways of improving staff attitudes.

## Care pathways

On the one hand, the paths that patients can follow, from different starting points, need to be described, agreed and standardized. On the other, patients with alcohol problems often lead chaotic lives and are unlikely to stay on a prescribed path for long.

Although pathways are necessary to help integrate and evaluate services, they are not a substitute for the personal relationships and care needed to work with patients and clients over the long term.

Integrated care is especially necessary for patients with physical health problems, whether caused by alcohol or not. The trigger for starting or renewing such care may be a hospital attendance at A&E with or without subsequent hospital admission. There are well established pathways from these points for engaging with CATs, but linkage with general practices, allowing continuity and coordination of care, appears less successful.

Anomalies were highlighted in the variable arrangements for accessing addiction psychiatry, which is sometimes integrated with CATs, while in other places GPs have to refer separately.

## **SESSION 4 CAN CLINICAL EXPERIENCE INFORM PUBLIC HEALTH POLICY?**

Practitioners at the meeting were in no doubt that their work involves front line experience of a huge societal problem. All could recount individual tragedies which had ruined lives and families, for which the most effective long term solution is not better care or services but policies to reduce regular excessive drinking in the community at large.

Discussion covered the following points:

- The over-riding need to reduce the overall population intake of alcohol.
- The lack of evidence that this can be achieved by educational measures alone (even though politicians persist in advocating education as a solution).
- The huge influence of the alcohol industry (one company aims "to own sociability").
- Poverty and deprivation add to the burden and impact of alcohol.

The meeting called for politicians with "gumption and long term vision", not only to provide resources but also to commit themselves to system-building over the long term.

It was noted that alcohol services are poorly resourced within the NHS, in relation to the problems that alcohol causes.

### **Cultural change**

- The same cultural changes are needed as happened with seatbelts and smoking. There is a feeling that change is slowly starting to happen. People tend not to drink at lunch time in the way they used to, but less so in deprived areas. There is still a culture of bragging about alcohol intake.
- Culture change needs to come from the top down, involving parents, politicians, the media etc.
- Media attitudes towards alcohol need to change.
- A societal change is required to make getting drunk unacceptable.
- People should be made aware that we are ALL paying for problem drinking, for example through tax contributions and through difficulties accessing A&E care on a Friday night.
- How do we change a culture? The evidence base for prevention and education is conflicting and unconvincing, perhaps due to a lack of research rather than negative results. Are the proposals around 'Framework for Action' evidence based? Do we need to take action before waiting for evidence? Research is often alcohol industry funded with unreliable results, and is often UK not Scotland based.

## Legal ways to reduce alcohol consumption

- A good thing
- The back-up of the Government's stance on alcohol helps when imparting messages about problem drinking to individual patients (as it was when the smoking ban was introduced).
- Minimum pricing is worth trying.
- Is access the issue or is it a cultural change that is needed? Did the smoking ban precede or follow a societal change? Has the smoking ban been completely successful, or has it increased alcohol consumption at home? Would minimum pricing result in people gaining alcohol from elsewhere e.g. abroad?
- The Alcohol bill 'Framework for Action' is currently being assessed by the Scottish parliament. This is regarded as a radical policy, similar to the smoking ban, its main plank being minimum alcohol pricing, but it also suggests a social responsibility levy on the alcohol industry. Current struggle to get the bill passed. Economic difficulties making this worse.
- Fewer shops should be licensed by councils to sell alcohol.
- 2 for 1 offers in supermarkets should be banned.
- Education and prevention in schools.
- Raise the legal age for purchasing alcohol to 21.
- ID should be mandatory for buying alcohol.
- Shops should lose their licenses if selling to underage.
- There should be powers to limit availability – keep alcohol displays away from checkouts, ban the sale of alcohol in corner shops, remove cheap alcohol from supermarkets.
- There is a role for minimum pricing, but also concern that people will buy illicit alcohol and if it goes underground – who gets that money?
- Ban advertising. Although this doesn't do much for adults, it is effective for youth.
- Concern re alcohol promotions e.g. happy hours and freshers' week at universities.
- Consider banning supermarkets from delivering large amounts of alcohol to homes.
- Ban the purchase of alcohol in petrol stations.
- Prevent the purchase of alcohol on credit.
- "Ripple Effect" document and other personal accounts of the harms of alcoholism are of value.

## Actions by GPs

- GPs could provide feedback to councils about shops with alcohol licenses and protest against new ones. Similarly for advertising.
- Doctors should consider objecting to new alcohol licences in their locality.
- GPs should feedback to their ADPs (Alcohol and Drug Partnership) with practical suggestions to resolving the local problems.
- Professional experience is a valuable form of evidence.
- Need to give a human face to the problem of alcoholism, based on individual examples.

- GPs should become political and feed back to Government. No one should die “young and yellow” – the description given by one GP of a female patient who had died from alcoholic liver poisoning.
- GPs need to become political and get patients to take their problems to their MSPs.
- GPs could write to MSPs and to Government about policies such as where alcohol is available, 2 for 1 offers, supermarket vouchers being used for alcohol, banning credit cards being used for alcohol, home deliveries from shops.
- Alcohol must not be glamorised in any way and needs to be portrayed realistically.
- "Every little helps"....

## Note

*As a result of the meeting, a letter was signed by 40 Deep End GPs and published in the Herald on Tuesday 14 September 2010 (Annex A). The Government's proposals on minimal alcohol pricing were defeated by the combined efforts of opposition parties one week later.*

# ANNEX A LETTER TO THE HERALD

13 September 2010

The Editor  
The Herald  
Glasgow

Dear Sir

We write as general practitioners working in the most deprived areas of Scotland, with special experience of the problems of alcohol. Our interest is not through choice, but because of the huge, recent and increasing importance of excessive alcohol consumption as a cause of premature death, physical illness and social harm affecting our young patients.

Research studies show the social patterning of alcohol problems, not only the higher levels of consumption in poor areas, but also the higher levels of harm for a given level of consumption. Death rates from alcohol liver disease are five times more common in poor areas compared with the most affluent areas.

Scotland's statistics are shocking, but "statistics are people with the tears wiped off". The current debate about alcohol pricing can lose sight of the misery and devastation that affects our patients and their families, especially the lasting effects on children. Drunken disorder is only the most obvious problem. Every one of us knows of tragic cases of young adults whose lives, and whose family lives, have been ruined by alcohol. Women are particularly vulnerable. No one should die young and yellow from chronic alcohol poisoning.

This is not an issue that can be left to personal responsibility or the massed efforts of health practitioners trying hard to stem the tide. Any measure, such as minimal alcohol pricing, which makes it more difficult for people to consume regular excessive amounts of alcohol should be seized, as a public health measure of the highest importance. Cross party support is the least we should expect from our politicians, especially those representing the most deprived constituencies, in confronting this very real and lethal epidemic.

**Signed by the following NHS general practitioners**

**Jim O'Neil** Lightburn Medical Centre  
**Margaret Craig** Allander Street Surgery  
**Stephen Macpherson** Elizabeth Day, Robert Jamieson Bridgeton Health Centre  
**Peter Wiggins** Castlemilk Health Centre  
**Catriona Morton** Michael Norbury Craigmillar Health Centre  
**Harjinder Bachu, Ian Aitken** Crail Medical Practice  
**Peter Cawston, John Nugent** Drumchapel Health Centre  
**John Goldie, Dhami Davinder, Emma Shepherd** Easterhouse Health Centre  
**Sally Al-Agilly** Edinburgh Road Surgery  
**Alison Macbeth, William Lam, Scott Wilson** Gilbertfield Medical Centre  
**Andrea Williamson, Ruth Spencer** Glasgow Homeless Health Service  
**Catherine Mills** Gorbals Health Centre  
**Euan Paterson, Stephanie Maguire, Anne Mullin** Govan Health Centre  
**Clare McCorkindale** Kelso St Surgery  
**Ronnie Burns** Parkhead Health Centre  
**Maria Duffy, Douglas McKnight, Nick Treadgold** Pollok Health Centre  
**Lindsey Pope** Port Glasgow Health Centre  
**Robert Mandeville, Louis Alguero, Petra Sambale, Douglas Rigg, Susan Langridge**  
Possilpark Health Centre  
**Helga Rhein** Sighthill Health Centre  
**Georgina Brown, John Candy** Springburn Health Centre  
**Roger Black** Whitevale Medical Group  
**Professor Graham Watt** University of Glasgow