

Alcohol Misuse Interventions

*Guidance on developing a local
programme of improvement*

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Practical steps to improve screening and brief interventions for hazardous and harmful drinkers and treatment for dependent drinkers

DH INFORMATION READER BOX

Policy	
HR/Workforce Management	Performance
Planning	IM & T
Clinical	Finance
	Partnership working
Document purpose	To provide guidance on developing and implementing programmes that can improve the care of hazardous, harmful and dependent drinkers
ROCR ref:	Gateway ref: 5694
Title	Alcohol Misuse Interventions Guidance on developing a local programme of improvement
Author	Department of Health
Publication date	14 November 2005
Target audience	PCT CEs, SHA CEs, Local Authority CEs, GOR RDsPH
Circulation list	NHS Trust CEs, Foundation Trust CEs, Directors of PH, GPs, Ds of Social Services, SHA DPHs, SHA Directors of Commissioning, SHA Directors of Performance, Regional Directors of Government Offices, Regional Directors of Public Health, specialist media, key stakeholders, alcohol service providers
Description	This document provides the policy context, evidence of associated harm and presents good economic reasons for action, outlining practical steps and new national tools to support local delivery of alcohol interventions
Cross ref	Choosing Health: making healthier choices easier (Gateway ref 4135)
Superseded docs	none
Action required	N/A
Timing	N/A
Contact details	The Department of Health Alcohol Policy Team Wellington House 135-155 Waterloo Road London SE1 8UG
For recipient use	

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Foreword



Alcohol is an important part of our social, economic and cultural life and the majority of adults drink alcohol on a regular basis to relax, to celebrate and to socialise. Every citizen is affected by alcohol whether they drink or not. However, alcohol is related to a range of serious problems for some individuals, their families and for the wider community.

It is vitally important that we take notice of the evidence that much alcohol-related harm is preventable. I am pleased to be able to draw your attention to this guidance, which supports organisations thinking about developing the alcohol misuse interventions that will help improve health, reduce inequalities, reduce demand and improve access for National Health Service (NHS) services.

Experience has demonstrated the importance of integrating action to reduce health inequalities into mainstream service delivery, with a focus on disadvantaged areas and groups. However, aiming to improve the health of the poorest fastest does not confine action to only the most disadvantaged and socially excluded – the poorest 30–40% of the population is where the greatest burden of disease exists and where this guidance can help organisations to make a significant difference.

We know that evidence-based alcohol interventions can potentially deliver quality and quantity of life benefits to the individual, their family and the community. However, there are also compelling economic reasons for NHS organisations and social services authorities to consider implementing improved screening and brief interventions for hazardous and harmful drinkers and treatment for dependent drinkers.

I welcome the practice outlined in this guidance as it can help organisations set the foundations for a high quality of alcohol care by building on the good work already under way, encouraging organisations to challenge barriers to improvement and to use innovation and creativity to find better ways of improving service provision and patient care. The evidence suggests that organisations taking the common-sense steps outlined in this document will reduce harm, prevent unnecessary deaths and help people to be healthier.

NHS organisations do not work in isolation – Primary Care Trusts (PCTs) and local authorities work alongside other local partners, particularly the criminal justice agencies, the independent sector, voluntary organisations and service users. Improving screening and brief interventions for hazardous and harmful drinkers and treatment for dependent drinkers can only be achieved through partnership with these key stakeholders, taking account of the whole range of health and social care services.

This is only the start. I am committed to working with our colleagues across government, reviewing progress, learning from what works best, and developing national guidance in light of that learning.

A handwritten signature in black ink, appearing to read 'Caroline Flint', with a stylized flourish at the end.

Caroline Flint
Public Health Minister

1. Introduction

- 1.1 This document provides guidance on developing and implementing programmes that can improve the care of hazardous, harmful and dependent drinkers. Whilst this document focuses on guidance for the development of screening and brief interventions, it is also part of a wider programme that will develop over time.
- 1.2 Building on the *Alcohol Harm Reduction Strategy for England*, the *Choosing Health* white paper delivery plan outlined the key steps that will support the commitments on alcohol set out in *Choosing Health: making healthy choices easier*.
- 1.3 This document provides further detail on the policy context and evidence of harm to NHS aspirations, individuals, families and communities. It presents powerful economic arguments for action, identifies practical steps for those implementing this guidance locally and introduces new, nationally developed tools that can be used by local organisations.
- 1.4 The *Alcohol Needs Assessment Research Project (ANARP)* (2005) report, gives the first detailed national picture of the need for treatment and the availability of provision and contributes valuable findings that lay the foundations for and direction of the recommended practice in this guidance document.
 - 1.4.1 ANARP indicates that the prevalence of Alcohol Use Disorders (AUDs) and access to treatment varies considerably across England.
 - Some areas have high levels of hazardous and harmful alcohol use (often associated with younger people and alcohol-related disorder) but relatively low levels of dependent drinkers (who tend to be older and experience a wide range of health harms). In other areas, the opposite is the case.
 - Provision of alcohol treatment services, which benefit older dependent drinkers, also varies, with some areas having wide disparities.
 - People with alcohol dependence are heavy consumers of health services, but are often not identified as having alcohol dependence.

- 1.4.2 Only 24% of referrals to alcohol services come from primary care, whereas 36% are self-referrals. This suggests:
- Primary care does not perform the same gatekeeping role for alcohol services as it does for some other medical disorders/diseases.
 - There is considerable potential for growth in the screening, identification and referral of individuals with patterns of hazardous, harmful and dependent use of alcohol in both primary and secondary care (including general hospitals and mental health services).
 - Screening, identification and referral could be extended to agencies outside of the NHS including criminal justice agencies and social services.
- 1.4.3 This new information from ANARP will be useful for national planning and provide benchmarks against which local areas can compare their local service networks.
- 1.5 It is estimated that alcohol misuse is now costing around £20 billion a year in England, including alcohol-related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace, and problems for those who misuse alcohol and their families, including domestic violence.
- 1.6 Total healthcare costs related to alcohol misuse have a middle estimate of £1.6 billion, the annual cost of other primary care services reaches a total of almost £0.5 billion and around £0.5 billion (35%) of accident and emergency (A&E) attendance and ambulance costs may be alcohol related. It is estimated that evidence-based alcohol treatment in the UK could result in net savings in the ratio of £5 saved for every £1 spent.
- 1.7 There is no absolute level of alcohol consumption at which harm invariably results. The definitions used here are those used in the World Health Organization's (WHO) categorisation of problem drinking. This refers to AUDs and specifies three categories:
- Hazardous drinking: people drinking above recognised sensible levels but not yet experiencing harm.
 - Harmful drinking: people drinking above sensible levels and experiencing harm.

- Alcohol dependence: people drinking above sensible levels and experiencing harm and symptoms of alcohol dependence.
- 1.8 This document can be used to support local delivery and sets out guidance for those implementing screening and brief interventions for harmful and hazardous drinkers and treatment for dependent drinkers.

2. Making it happen locally

2.1 **Local Action: guidance to support delivery of a local programme of improvement for alcohol misuse interventions**

2.1.1 The *Alcohol Harm Reduction Strategy for England* identifies a high level of alcohol misuse and alcohol-related harm in society, insufficient focus on alcohol treatment and limited information on whether service provision meets demand. *Choosing Health* identified reducing harm and encouraging sensible drinking as a priority. This guidance focuses on improving screening and delivery of brief interventions to hazardous and harmful drinkers and improved treatment for dependent drinkers.

2.1.2 In line with the more devolved planning and performance system for health and social care as set out in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06-2007/08*, PCTs can set local targets in response to local needs and priorities without prescriptive guidance from the Department of Health (DH) or Strategic Health Authorities (SHAs). The above document does set out a framework of principles for developing local plans and target setting, asking PCTs to ensure that they:

- are in line with population needs;
- address local service gaps;
- delivery equity;
- are evidence based;
- are developed in partnership with other NHS bodies, local authorities and other partners; and
- offer value for money.

2.1.3 This document suggests practical steps that PCTs can take, using the above framework, to improve the identification and treatment of individuals whose drinking is potentially hazardous, is causing harm to themselves or others or arises from a dependence on alcohol. (See Annex C.)

- 2.1.4 While organisations may want to deliver innovative solutions to old problems, they may also want to consider maintaining existing levels of investment and service and include existing service providers as part of the solution whenever possible.
- 2.1.5 Guidance on practical steps for those PCTs considering the development of local plans to improve screening, brief interventions and care for hazardous, harmful and dependent drinkers:
- (a) Assess local need, current provision and levels of investment for screening, brief interventions and services for dependent drinkers across the local health and social care economy.
 - (b) As part of an assessment of local need for the entire pathway, greatest impact may be made if screening and brief interventions are offered to hazardous and harmful drinkers who:
 - 1) attend primary care as new registrations or with a pre-existing condition where alcohol may contribute to the harm, or are perceived by their General Practitioner (GP) as being at an increased risk of developing health conditions because of excessive drinking;
 - 2) attend other hospital health care settings responding to alcohol-related harms, for example STD clinics or fracture clinics; and
 - 3) consideration should be given to extending screening and brief intervention to those attending a non-NHS service, for example in a criminal justice setting (Public prison primary care provision is now almost universally PCT commissioned in England and services are often provided by NHS Trusts).
 - (c) Identify local champions to support implementation, such as a regional and local public health lead, a GP with a specialist interest, a hospital consultant, a substance misuse consultant, voluntary services, service users and a lead PCT commissioner.
 - (d) Directors of Public Health (DPHs) can be key contributors by steering this important programme at a PCT and SHA level in discussion with Directors of Commissioning and Performance Directors.
 - (e) Agree local arrangements for the planning and commissioning of services designed to support the implementation of screening and brief interventions, and improve access to other NHS-commissioned services. This would include identifying a lead commissioner.

- (f) Identify links with drug treatment commissioning to ensure clients with dual drug and alcohol problems receive appropriate interventions for their alcohol use while in drug treatment. The use of the pooled drug treatment budget can facilitate this.
- (g) For rapid progress, local organisations may consider appointing and training an Alcohol Intervention Specialist(s) (G or H Grade Nurse or equivalent), with responsibility for co-ordinating and implementing arrangements for screening, the provision of information and brief interventions within a setting(s) identified locally, and identifying pathways to specialised treatment.
- (h) Establish a project support network or group.
- (i) Publish a guide to local services.
- (j) Strengthen local planning on taking these practical steps by agreeing and setting local goals with local authorities and other key stakeholders.

2.1.6 PCTs and local authorities, the criminal justice agencies and voluntary agencies are key members of local and regional partnerships. PCTs are responsible for the commissioning of healthcare services for local prison populations. Responsibility for commissioning crime-related healthcare programmes aimed at behaviour change in offenders will fall under the new National Offender Management Service (NOMS). Commissioners in PCTs may work in partnership with NOMS to commission screening, brief interventions and treatment for alcohol-misusing offenders.

2.1.7 However, ongoing work is required to promote understanding of each other's role in crime and drugs partnerships, particularly focusing on the Tackling Violent Crime Programme areas (alcohol and domestic violence).

2.1.8 In the interests of strong multi-agency working, PCTs generally agree shared objectives with local authorities and other partners through Local Strategic Partnerships (LSPs).

2.1.9 Increasingly, Local Area Agreements (LAAs) will become the local planning process for agreeing locally shared objectives and the strategies and funding to achieve them. LAAs developed by the pilot areas have shown that they present a considerable opportunity to engage local authorities and other partners in the health agenda, and to bring health inequalities and the health and social care interface to the forefront of local community planning.

- The health and social care input in phase two LAAs (from April 2006) is focused on public health and on services to adults at the interface between health and social care agencies.
 - For phase two LAAs, there is a need to ensure that LAA proposals are consistent and aligned with already agreed Local Delivery Plans (LDPs), through local targets or agreed contributions to national priorities.
 - There should be scope for the LAA to build on the LDP, for example by identifying joint action to tackle the wider determinants of health such as the 'reducing harm and encouraging sensible drinking' priority identified in *Choosing Health*.
- 2.1.10 ANARP, findings from the Screening and Brief Intervention Trailblazer projects, Models of Care for Alcohol Misusers (MoCAM) and the *Review of the Effectiveness of Treatment for Alcohol Problems* will be available to support organisations locally. (See Annex E)
- 2.2 **Regional Support to deliver a local programme of improvement for alcohol misuse interventions (see Annex D)**
- 2.2.1 Beginning in January 2006, nine regional conferences will be held, in partnership with the DH Regional Directors of Public Health (RDsPH), to discuss the emerging evidence and practice on screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.
- 2.2.2 Government Offices (GOs), Regional Assemblies and Regional Development Agencies play an important role in delivering the wider determinants of health and in co-ordinating regional activities.
- 2.2.3 As part of DH, the nine RDsPH and their Public Health Groups (RPHGs) are co-located in each of the regional GOs and are available as a resource to provide advice and guidance in support of the local delivery of screening, brief interventions and treatment for hazardous, harmful and dependent drinkers. This will form part of their regional role in support of development and implementation of cross-government policy and action on alcohol.
- 2.2.4 In particular, DH RPHGs can offer advice and guidance in support through:
- reviewing existing partnership structures and working groups to ensure overlaps are kept to a minimum and that work done in one forum is built on by another (where agendas overlap, added value could be achieved by giving consideration to merging or linking working groups);

- facilitating partner agencies understanding of each other's organisations, including awareness of targets, focus, drivers etc;
- providing a link between networks already developed within the region which bring together community safety and health individuals and disseminating information which is of common interest;
- supporting the NHS to provide a link for post-release health care planning between those PCTs with a prison and those without and effective management of alcohol-related treatment and care for offenders;
- advise on gaps, and where possible, commission research to link crime and health information on a regional basis and provide information on other available data sources;
- provision of guidance and assistance on information sharing and good practice in analysis and interpretation of data and intelligence at local and regional levels;
- supporting the NHS in commissioning the evaluation of projects and dissemination of good practice;
- oversight of NHS workforce development plans ensuring that these consider the training and development needs of PCT and other NHS staff and Board members joining partnerships and how these could be met;
- provision of advice to the NHS and particularly PCTs on how they can engage with communities and groups in line with the Office of the Deputy Prime Minister (ODPM) 'How to' guide on engagement for integrated partnerships in respect of crime, alcohol and drugs.
- their role as the normal route of communication between the national DH policy team and the NHS on all aspects of alcohol policy development and implementation. This will ensure that concerns and advice from the NHS informs policy development and that DH guidance can be effectively and rapidly disseminated.

2.2.5 LAAs are negotiated and agreed by regional GO staff on behalf of the Government. DH RDsPH represent DH in this process supported by SHAs; SHAs also have a role to agree the PCT contribution to the LAA and in supporting PCTs to deliver health improvements.

- 2.2.6 Existing Public Health Observatory (PHO) work on alcohol related health will be supported by regional-level information from ANARP. This can supplement other local information and be used by PCTs to help determine local levels of hazardous, harmful and dependent drinkers and to identify gaps in local provision in line with MoCAM. A web-based tool will be available from December 2005 and will be further developed with assistance from the North West PHO.
- 2.3 **National Support for the delivery of a programme of improvement for alcohol misuse interventions (see Annex E)**
- 2.3.1 PCTs have been notified that £15m per annum will be included within the PCTs' general allocation from 2007/8 onwards to 'help PCTs to improve their local arrangements for commissioning and delivering alcohol interventions' (9 February 2005 – AWP(06-07)PCT01).
- 2.3.2 Research evidence on screening and brief interventions indicates that many individuals benefit from brief interventions. However, in order to strengthen the UK evidence base, Trailblazer projects will be taking place to determine the impact of targeted screening and brief interventions in primary care, hospital and criminal justice settings. The projects will also identify the best screening tools and best intervention methods tailored to these various settings. These projects will begin in Spring 2006 and the final report will be provided by Summer 2008. However, the projects will release interim findings as they emerge and produce formal six-monthly progress reports that will be available to stakeholders.
- 2.3.3 ANARP gives the first detailed national picture of the need for treatment and the availability of provision and contributes valuable findings that support this guidance document.
- 2.3.4 MoCAM, DH and National Treatment Agency (NTA), provides a framework and guidance on the commissioning and provision of local alcohol treatment systems for hazardous, harmful and dependent drinkers. It provides support for organisations on developing comprehensive local integrated pathways for alcohol care, including for those in vulnerable circumstances, such as people with mental illness, homeless people and drug users who also misuse alcohol. (From late 2005)

- 2.3.5 Published alongside MoCAM, together with a summary document detailing key findings, is the *Review of the Effectiveness of Treatment for Alcohol Problems*, NTA. The summary is sufficient to inform Chief Executives and other senior managers in SHAs, PCTs, local authorities and other partners. Commissioners, service providers and others with a significant role or interest in alcohol-related issues should consult the full review document, which will act as a key reference work in the coming years.
- 2.3.6 The programme will be supported by the workforce elements of *Choosing Health*. The national workforce strategy and competency framework underpins the development of education and skills and work across the health and social care community, local government, business communities and the voluntary sector and drives the development of local capacity and capability.
- 2.3.7 The *Choosing Health Planning and Performance Toolkit for PCTs and their Partners* lays out how local planning for *Choosing Health* (including alcohol as a priority) sits alongside mainstream NHS planning (Local Delivery Plans).
- 2.3.8 The *Choosing Health Planning and Performance Toolkit for PCTs and their Partners* commits DH to continue to work closely with the independent inspectorates to ensure that the inspection systems are consistent with each other, are aligned with national priorities to improve population health and continue reducing the burden of bureaucracy on frontline organisations. We are looking at how the NTA and Health Care Commission work on drug treatment can be used as a model for alcohol interventions.
- 2.3.9 As part of a wider, cross-government alcohol harm reduction communications plan, a comprehensive communications programme is being developed to help NHS organisations, local authorities, criminal justice agencies, service providers, the independent sector, voluntary organisations, service users and other partners to learn about the programme of improvement to develop alcohol misuse interventions.
- 2.3.10 Beginning in January 2006 DH will hold nine regional conferences, in partnership with the DH RDsPH, to discuss the emerging evidence and practice on screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.

3. How to use the annexes

- 3.1 The following annexes provide the context for organisations considering screening, brief interventions and treatment for hazardous, harmful and dependent drinkers and lay out a full range of practical steps for local action with regional and national support.
- 3.2 **Annex A: Good economic reasons for alcohol misuse interventions**
 - 3.2.1 This annex presents economic arguments for reducing demand and improving access for NHS services through reducing associated alcohol harm.
- 3.3 **Annex B: Reducing the burden of associated alcohol harm**
 - 3.3.1 This table identifies NHS and cross-government targets and links them to evidence of associated alcohol harm and identifies the potential contribution that alcohol misuse interventions can make to reduce inequalities, reduce demand and improve access for NHS services.
 - 3.3.2 PCTs can use this table, both in the wider commissioning process to reduce inequalities, reduce demand and improve access for NHS services and when determining the specific commissioning of screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.
- 3.4 **Annex C: Local action**
 - 3.4.1 This table builds on *Delivering Choosing Health* and *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08*. The table sets out guidance on practical steps for local organisations implementing screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.
 - 3.4.2 PCTs can use these tables, together with *Delivering Choosing Health* and *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08*, within their wider local commissioning processes when considering the development of local

commissioning and local targets to implement screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.

3.5 **Annex D: Regional support**

3.5.1 This annex lays out the support available from DH RDsPH and regional PHOs for local organisations implementing screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.

3.6 **Annex E: National support**

3.6.1 This annex identifies the new national tools available to support local organisations implementing screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.

3.7 **Annex F: Practice examples**

3.7.1 This annex provides examples of current practice.

3.8 **Annex G: The policy context**

3.9 **Annex H: Associated documents**

3.9.1 How to find associated guidance documents and sources of support.

3.10 **Annex I: Glossary**

ANNEX A:

Good economic reasons for alcohol misuse interventions

1. **This annex sets out the possible economic benefits of successful programmes for screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.**
2. **The Challenge:**
 - 2.1 We know that alcohol interventions can potentially deliver quality and quantity of life benefits to individuals with alcohol problems, their family and the community.
 - 2.2. The harm caused by hazardous, harmful and dependent drinking is associated with many other health harms to individuals and society. We know that excessive drinking is a major cause of disease and injury, accounting worldwide for 9.2% of disability-adjusted life years (DALYs) with only tobacco smoking and high blood pressure as higher risk factors¹. In Europe, mental and behavioral problems due to alcohol are the fifth highest cause of DALYs, exceeded only by depression, coronary heart disease, dementias and stroke.²
 - 2.3 Although there is a wide body of evidence associating alcohol misuse with heart disease and cancer the most robust evidence impacts the DH target *“to reduce mortality rates from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole”*.
 - Nearly 5,000 (3.5%) cancer deaths per annum are attributable to alcohol. Alcohol is causally related to cancers of the oral cavity and pharynx, larynx, oesophagus and liver, while there is suggestive but inconclusive evidence for a causal role in rectal and breast cancer⁴
 - Between 15,000 and 22,000 deaths in England and Wales each year are associated with alcohol misuse and alcohol-related liver disease accounts for over 4,500 of these – a 90% increase over the past decade⁴

2.4 There is evidence that the DH target to “*substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole*”, is impacted by hazardous, harmful and dependent drinkers.

- Heavy drinking constitutes a severe risk of cardiovascular disease, with 1,200 associated deaths per year due to haemorrhagic stroke and 10% of deaths due to hypertension⁴

2.5 Up to 35% of all A&E attendance and ambulance costs (around £0.5 billion) may be alcohol-related.⁶

In A&E departments at peak times:⁴

- 41% of all attendees were positive for alcohol consumption
- 14% of attendees were intoxicated
- 43% were identified as problematic drinkers after screening
- 70% of attendances between midnight and 5 am are alcohol related
- staff may experience violence

Reasons for attendance at A&E for those alcohol positive were significantly more commonly:⁴

- violent assault incident involving weapons
- road traffic accidents
- psychiatric emergencies
- deliberate self harm episodes

2.6 Alcohol-related diseases account for 1 in 8 NHS bed days (around 2 million) and 1 in 80 NHS day cases (around 40,000).⁴

- 2.7 150,000 hospital admissions each year are associated with excessive drinking. Of which roughly 33,000 are due to alcohol-related liver disease and between 30,000 and 36,000 are people who are diagnosed as alcohol dependent.⁴

3. The reward:

- 3.1 Whilst there is research on the breadth of associated harm caused by hazardous, harmful and dependent drinking there is also some evidence of the economic impact of problematic alcohol consumption.
- 3.2 For example, a recent exemplar analysis (DH calculation) of an average A&E department has modelled the potential impact of brief interventions for hazardous and harmful drinkers on the percentages of attendances at A&E seen within the four-hour target.
- 3.2.1 The model suggests that the use of screening and brief interventions could impact on alcohol consumption to the extent that it could reduce patients' average journey time through A&E by between 16% and 6%. In a busy A&E department this could be a significant improvement.
- 3.2.2 Respective changes in the percentages meeting the four hour target will be more modest (97% to 98% in a typical large A&E department) but this is primarily because A&E departments have been meeting or close to meeting their targets.
- 3.3 Patients who received a brief intervention following visits to a London accident and emergency unit had made on average 0.5 fewer repeat visits in the following 12 months compared to those in a control group.
- 3.4 Recent studies suggest that alcohol treatment has both short and long term savings and analysis from the UKATT Study²⁹ suggests that for every £1 spent on treatment, the public sector saves £5.
- 3.5 The provision of alcohol treatment to 10% of the dependent drinking population within the United Kingdom would reduce public sector resource costs by between £109m and £156m each year.
- 3.6 In a Scottish study alcohol treatment reduced long-term health care costs by between £820 and £1,600 per patient (2002/3 prices).

- 3.7 The direct cost of a brief intervention delivered to hazardous or harmful drinkers was calculated to be only £20 in 1993.⁴
- 3.8 A recent WHO study³¹ estimated that the cost-effectiveness of brief interventions for hazardous and harmful drinking is approximately £1,300 per year of ill-health or premature death averted. This is nearly equivalent to the cost-effectiveness of smoking cessation interventions which is about £1,200.
- 3.9 A recent trial found that brief intervention trials can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 8.7 fewer mean drinks per week with a significant effect on recommended or safe alcohol use.¹⁸
- 3.10 The number of hazardous or harmful drinkers that need to receive brief interventions for one to reduce their drinking to low risk levels is about 8. This compares favorably with smoking cessation where 20 people need to be treated and 10 if nicotine replacement therapy is included, for one to change their behavior.
- 3.11 Evidence suggests that hazardous and harmful drinkers receiving brief interventions were twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to drinkers receiving no intervention.¹⁷
- 3.12 If consistently implemented, GP-based interventions would reduce levels of drinking from hazardous or harmful to low risk levels for 250,000 men and 67,500 women each year.

Reducing the burden of associated alcohol harm

Department of Health PSAs	Evidence of associated alcohol harm and its burden on the NHS ¹⁵	Reducing the burden: impact of effective interventions
<p>Substantially reduce mortality rates by 2010:</p> <ul style="list-style-type: none"> From heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole (Data source: ONS mortality statistics) <p>NHS Local Delivery Plan data-monitoring lines:</p> <p>PSA01a: Cardiovascular disease mortality rates among under 75s (reduction in levels)</p> <p>PSA01b: Practice based registers of patients at risk of CHD (GP screening of high risk patients)</p> <p>PSA01c: Blood pressure (GP screening of high risk patients)</p> <ul style="list-style-type: none"> From cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole (Data source: ONS mortality statistics) 	<ul style="list-style-type: none"> Heavy drinking constitutes a severe risk of cardiovascular disease, with 1,200 associated deaths per year due to haemorrhagic stroke and 10% of deaths due to hypertension. Nearly 5,000 (3.5%) cancer deaths per annum are attributable to alcohol. Alcohol is causally related to cancers of the oral cavity and pharynx, larynx, oesophagus and liver, while there is suggestive but inconclusive evidence for a causal role in rectal and breast cancer.¹⁶ 	<p>Evidence suggests that hazardous and harmful drinkers receiving brief interventions were twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to drinkers receiving no intervention.¹⁷</p> <p>A recent trial found brief intervention trials can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 8.7 fewer mean drinks per week with a significant effect on recommended or safe alcohol use.¹⁸</p> <p>If consistently implemented, GP-based interventions would reduce levels of drinking from hazardous or harmful to low risk levels for 250,000 men and 67,500 women each year.</p> <p>Eight hazardous or harmful drinkers need to receive brief interventions in order for one to reduce their drinking to low risk levels. This compares favourably with smoking cessation where 20 people need to be treated to show a change in one (but this improves to one in 10 if nicotine replacement therapy is included).</p>

continued

Department of Health PSAs	Evidence of associated alcohol harm and its burden on the NHS ¹⁵	Reducing the burden: impact of effective interventions
<p>NHS Local Delivery Plan data-monitoring lines: Cancer mortality and inequalities</p> <p>PSA03a: Cancer mortality rates among under 75s (reduction in levels)</p> <p>PSA03b: Cancer – implementation of NICE Improving Outcomes Guidance</p> <p>PSA03c: Bowel cancer screening</p> <ul style="list-style-type: none"> From suicide and undetermined injury by at least 20% by 2010 (Data source: ONS mortality statistics). <p>NHS Local Delivery Plan data-monitoring lines: PSA05a: Suicide rates (reduction in levels – mortality rate from suicide and undetermined injury per 100,000 directly age standardised population)</p> <ul style="list-style-type: none"> Infant mortality <p>Supporting strategies:</p> <ul style="list-style-type: none"> Tackling Health Inequalities: a programme for action – July 03 www.dh.gov.uk/assetRoot/04/01/93/62/04019362.pdf NHS Cancer Plan: a plan for investment, a plan for reform – Sept 2000 www.dh.gov.uk/assetRoot/04/01/45/13/04014513.pdf National Service Framework for Coronary Heart Disease – March 2000 www.dh.gov.uk/assetRoot/04/05/75/26/04057526.pdf National Suicide Prevention Strategy – NIMH(E) 	<ul style="list-style-type: none"> Between 15,000 and 22,000 deaths in England and Wales each year are associated with alcohol misuse, and alcohol-related liver disease accounts for over 4,500 of these – a 90% increase over the past decade. 15–25% of suicides and 65% of suicide attempts are related to alcoholism. 20–30% of all accidents have alcohol as a factor, with up to 1,700 associated deaths per year. 10% of children of alcohol-dependent mothers suffer from foetal alcohol effects. 	<p>Evidence shows that drinkers may reduce their consumption by as much as 20% as a result of a brief intervention and that heavy drinkers who receive an intervention are twice as likely to cut their alcohol consumption as heavy drinkers who receive no intervention.¹⁹</p> <p>There is good evidence that when GPs and nurses are adequately trained and supported for this work, screening and brief interventions activity increase.²⁰</p> <p>There is evidence that extended brief interventions (several visits) in primary care settings for women decreased alcohol intake by an average 51g per week.²¹</p>

<p>Department of Health PSAs</p>	<p>Evidence of associated alcohol harm and its burden on the NHS¹⁵</p>	<p>Reducing the burden: impact of effective interventions</p>
<ul style="list-style-type: none"> Reduce the under-18 conception rate by 50% by 2010 (from the 1998 baseline) as part of a broader strategy to improve sexual health (Data source: ONS conception statistics). DH/DFES <p>NHS Local Delivery Plan data-monitoring lines: PSA11a: Under 18 conception rates</p> <p>Local Authority Best Value Performance Indicator: BVP197 in the health and social care (children) grouping – Teenage Pregnancy</p> <p>Supporting strategies: National Teenage Pregnancy Strategy – June 1999 www.dfes.gov.uk The National Strategy for Sexual Health and HIV – July 2001 www.dh.gov.uk</p>	<ul style="list-style-type: none"> A study of students aged 19 in North East England between 1989 and 1990 found that, after drinking, 35% had sex without contraception.²² Research shows that after drinking alcohol one in seven 16–24 year olds have had unsafe sex, one in five have had sex they later regretted, one in ten have been unable to remember whether they had sex the night before and 40% think they are more likely to have casual sex.²³ A survey of 13–14 year olds found that 40% were “drunk or stoned” when they first experienced sexual intercourse.²⁴ 	<p>Brief interventions have been shown to reduce the level of alcohol consumption over three months among college students who were drinking excessively.</p>

Department of Health existing targets to be maintained	Evidence of associated alcohol harm and its burden on the NHS²⁵	Reducing the burden: impact of effective interventions
<ul style="list-style-type: none"> Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005 and a comprehensive child and adolescent mental health service by 2006. <p>NHS Local Delivery Plan data-monitoring lines: PSA05b: CPA 7 day follow-up (increase the percentage of people on enhanced CPA receiving follow-up by phone or face-to-face contact within 7 days of discharge from hospital).</p> <p>Local Authority Best Value Performance Indicator: BV176: to assess the overall provision and effectiveness of local authority services designed to help victims of domestic violence and prevent further domestic violence.</p> <p>Supporting strategies:</p> <ul style="list-style-type: none"> National Service Framework for Mental Health – Sept 1999 www.dh.gov.uk Delivering Race Equality in Mental Health Care – Jan 2005 www.dh.gov.uk Developing Choice, Responsiveness and Equity in Health and Social Care – NIMH(E) Mental Health Promotion programme and ‘Shift’: the programme to reduce stigma – NIMH(E) Social Inclusion Programme – NIMH(E) www.nimhe.org.uk 	<ul style="list-style-type: none"> 15–25% of suicides and 65% of suicide attempts are related to problem drinking. 20–30% of all accidents have alcohol as a factor, with up to 1,700 associated deaths per year. During a 12 month period there were 72,500 hospital admissions with a diagnosis of mental and behavioural disorders due to alcohol, including 31,300 for alcohol dependence syndrome.²⁶ Alcohol has a serious effect on behaviour and relationships in the home, affecting the mental health and behaviour of children of alcohol-misusing parents.²⁷ Hazardous, harmful and dependent drinking is linked to psychiatric morbidity including clinical depression. Around a third of incidents of domestic violence (360,000) are linked to alcohol misuse. Heavy drinking by victims is also a risk factor. Around 1 million children live in families where one or both parents misuse alcohol. An analysis of NSPCC Helpline calls showed parental alcohol misuse to be a factor in 23% of child neglect calls, 13% of calls about emotional abuse, 19% of calls about physical abuse and 5% of sexual abuse calls. By the age of 15 young people in families with a problem drinking parent have higher rates of psychiatric disorder, between 2.2 and 3.9 times higher than other young people.²⁸ 	<p>The provision of alcohol treatment to 10% of the dependent drinking population within the United Kingdom would reduce public sector resource costs by between £109m and £156m each year.</p> <p>In a Scottish study, alcohol treatment reduced long-term health care costs by between £820 and £1,600 per patient (2002/3 prices).</p> <p>Recent studies suggest that alcohol treatment has both short and long term savings, and analysis from the UKATT Study²⁹ suggests that for every £1 spent on treatment, the public sector saves £5.</p> <p>The direct cost of a brief intervention delivered to hazardous or harmful drinkers was calculated to be only £20 in 1993.³⁰</p> <p>A recent WHO study³¹ estimated that the cost-effectiveness of brief interventions for hazardous and harmful drinking is approximately £1,300 per year of ill-health or premature death averted. This is nearly equivalent to the cost-effectiveness of smoking cessation interventions which is about £1,200.</p> <p>Evidence suggests that brief interventions are effective in opportunistic (non-treatment seeking) samples and when typically delivered by healthcare professionals.³²</p>

<p>Department of Health existing targets to be maintained</p>	<p>Evidence of associated alcohol harm and its burden on the NHS²⁵</p>	<p>Reducing the burden: impact of effective interventions</p>
<p>Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:</p> <ul style="list-style-type: none"> • increasing the proportion of older people being supported to live in their own homes by 1% annually in 2007 and 2008 (Data source: DH RAP return, ONS population estimates) • increasing by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care (Data source: DH HH1, DH SR1 return, PAF PI published data). <p>DH</p> <p>Supporting strategies: National Service Framework for Older People www.dh.gov.uk/assetRoot/04/07/12/83/04071283.pdf</p>	<ul style="list-style-type: none"> • A study of patients admitted acutely to a care of the elderly department identified 8% as alcohol misusers.³³ 	

<p>Department of Health existing targets to be maintained</p> <ul style="list-style-type: none"> • a four-hour maximum wait in A&E from arrival to admission, transfer or discharge • guaranteed access to a primary care professional within 24 hours and to a primary care doctor within 48 hours • every hospital appointment booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs <p>Supporting strategies: Delivering the NHS Improvement Plan: The Workforce Contribution – Nov 2004 www.dh.gov.uk</p>	<p>Evidence of associated alcohol harm and its burden on the NHS²⁵</p> <p>Up to 35% of all A&E attendance and ambulance costs (around £0.5 billion) may be alcohol-related.³⁴</p> <p>In A&E departments at peak times:³⁵</p> <ul style="list-style-type: none"> • 41% of all attendees were positive for alcohol consumption • 14% of attendees were intoxicated • 43% were identified as problematic drinkers after screening • 70% of attendances between midnight and 5 am are alcohol related • staff may experience violence <p>Reasons for attendance at A&E for those alcohol positive were significantly more commonly:³⁶</p> <ul style="list-style-type: none"> • violent assault incidents involving weapons • road traffic accidents • psychiatric emergencies • deliberate self-harm episodes <p>Alcohol-related diseases account for 1 in 8 NHS bed days (around 2 million) and 1 in 80 NHS day cases (around 40,000).³⁷</p> <p>150,000 hospital admissions each year are associated with excessive drinking. Of these roughly 33,000 are due to alcohol-related liver disease and between 30,000 and 36,000 are people who are diagnosed as alcohol dependent.³⁸</p>	<p>Reducing the burden: impact of effective interventions</p> <p>Patients who received a brief intervention following visits to a London accident and emergency unit had made on average 0.5 fewer repeat visits in the following 12 months compared to those in a control group.</p>
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<p>Supporting cross-government PSAs</p> <p>Reduce crime by 15% and further in high crime areas, by 2007–08. Home Office</p>	<p>Evidence of associated alcohol harm and its burden on the wider determinants of health³⁹</p> <ul style="list-style-type: none"> • Offenders have been found to be intoxicated in 30% of sexual offences, 33% of burglaries and 50% of street crime. • In addition, around half of all violent crimes (1.2 million incidents) are alcohol related. • 63% of men and 39% of women coming into prison were classed as hazardous drinkers in the year leading up to custody.⁴⁰ • Nearly two-thirds of male prisoners and over one-third of female prisoners have an established alcohol problem.
<p>Tackle social exclusion and deliver neighbourhood renewal, working with departments to help them meet their PSA floor targets, in particular narrowing the gap in health, education, crime, worklessness, housing and liveability outcomes between the most deprived areas and the rest of England, with measurable improvement by 2010. ODPM</p> <p>Supporting Strategies: Making it Happen in Neighbourhoods: The National Strategy for Neighbourhood Renewal Four Years On. www.neighbourhood.gov.uk</p>	<ul style="list-style-type: none"> • About half of homeless people are dependent on alcohol. • Problem drinking is twice as common in the poorest than in the most affluent of socio-economic groups, and higher levels of consumption have been consistently observed in some deprived groups such as unemployed people.⁴¹ • Evidence indicates that young men aged 25 to 39 in the unskilled manual class are between 10 and 20 times more likely to die from alcohol-related causes than those in the professional class, and men aged 55 to 64 in the unskilled manual class are 2.5 to 4 times more likely to die from alcohol-related causes.⁴² • Prisons afford opportunity for effective engagement with members of deprived communities: people in prison are 13 times more likely to be unemployed and 13 times more likely to have been in local authority care than members of the wider population.⁴³
<p>Reduce the number of people killed or seriously injured in Great Britain in road accidents by 40% and the number of children killed or seriously injured by 50%, by 2010 compared with the average for 1994–98, with greater reductions in disadvantaged communities. DfT</p> <p>Supporting Strategies: Tomorrow's Roads: Safer for Everyone www.dft.gov.uk</p>	<ul style="list-style-type: none"> • Drink driving was still associated with 5% of all road accidents and 18% of road deaths in 2004 <ul style="list-style-type: none"> – the most up-to-date reference suggests that 7% of all accidents and 17% of all road deaths involved a driver who was over the drink-drive limit.⁴⁴

<p>Supporting cross-government PSAs</p> <p>Improve children's communication, social and emotional development so that by 2008, 50% of children reach a good level of development at the end of the Foundation Stage and reduce inequalities between the level of development achieved by children in the 20% most disadvantaged areas and the rest of England.</p> <p>DfES/Sure Start Unit/DWP</p> <p>Supporting Strategies: Choice for Parents, the Best Start for Children: A Ten Year Strategy for Childcare – Dec 2004 www.everychildmatters.gov.uk</p>	<p>Evidence of associated alcohol harm and its burden on the wider determinants of health³⁹</p> <ul style="list-style-type: none"> • Around a third of incidents of domestic violence (360,000 per year) are linked to alcohol misuse. Heavy drinking by victims is also a risk factor. • Around 1 million children live in families where one or both parents misuse alcohol • An analysis of NSPCC Helpline calls showed parental alcohol misuse to be a factor in 23% of child neglect calls, 13% of calls about emotional abuse, 19% of calls about physical abuse and 5% of sexual abuse calls. • By the age of 15 young people in families with a problem drinking parent have higher rates psychiatric disorder, between 2.2 and 3.9 times higher than other young people.⁴⁵
<p>Demonstrate progress on increasing the employment rate. DWP/HMT</p> <p>Supporting Strategies: DWP Five Year Strategy: Opportunity and Security Throughout Life – Feb 2005 www.dwp.gov.uk</p>	<ul style="list-style-type: none"> • A census of alcohol services found that, of the 10,000 people receiving help for their drinking problems each day, 36% were unemployed.⁴⁶ • 13% of 16 to 18 year old non-participants in education and employment are dependent on alcohol compared with 5% of participants.⁴⁷

Annex C: Local action

Local action: guidance for PCTs	
Principles for planning and commissioning	Practical steps that PCTs can take
<p>Population needs</p> <p>PCTs will want to work in partnership to assess local need, current investment and provision of screening and brief interventions and services for dependent drinkers across the local health, social care and criminal justice pathways and to consider the different needs and priorities within each community.</p>	<p>Assess local need, current provision and levels of investment for screening and brief interventions and services for dependent drinkers across the local health and social care economy.</p> <p>As part of their assessment of the entire pathway, consider whether screening and brief interventions are offered to hazardous and harmful drinkers who:</p> <ul style="list-style-type: none"> • attend primary care as a new registration or with a pre-existing condition where alcohol may contribute to the harm, or are perceived by the GP as being at an increased risk of developing health conditions because of excessive drinking; • attend other hospital health care settings; for example STD clinics or fracture clinics; or • attend a non-NHS service, for example, in a criminal justice setting (public prison primary care provision is now almost universally PCT commissioned in England and services are often provided by NHS Trusts). <p>PCTs can act collaboratively on a pan-PCT or wider basis, to secure services and service improvement when specialist service provision would benefit from this.</p>
Local service gaps	<p>Identify a lead PCT commissioner.</p> <p>Identify local champions to support implementation, such as a hospital consultant, regional and local public health lead, a substance misuse consultant, a GP with a specialist interest, voluntary services, and service users.</p> <p>Establish a project support or network group.</p> <p>Directors of Public Health (DPH) can be key contributors by steering this important programme at a PCT and SHA level in discussion with Directors of Commissioning and Performance Directors.</p> <p>DPHs and Directors of Commissioning support local alcohol commissioners (who may already be employed as Joint Commissioners).</p>

<p>Local Action: guidance for PCTs</p>	
<p>Principles for planning and commissioning</p>	<p>Practical steps that PCTs can take</p> <p>Consider appointing and training an Alcohol Intervention Specialist(s) (G or H Grade Nurses or equivalent) with responsibility for co-ordinating and implementing arrangements for screening, the provision of information and brief interventions within a setting(s) determined locally, and identifying pathways to specialised treatment.</p> <p>Publish a guide to local services.</p> <p>Use opportunities available within the new General Medical Services (GMS) contract to deliver enhanced services and a range of models of prevention to meet need.</p> <p>For people requiring planned hospital care, use core and flexible contracts to support the flow of funds to alternative providers where patient choice and/or capacity demands dictate.</p> <p>Agree explicit criteria for referral and treatment thresholds and trigger points within service level agreements and contracts. This includes involving service users more directly in decisions about interventions and treatment.</p> <p>Have appropriate contracting and monitoring arrangements in place at PCT level to ensure that sustainable interventions and services are commissioned and that local monitoring arrangements identify the impact on identified areas of NHS service demand and access.</p>
<p>Equity</p> <p>PCTs and their partners can apply these common equity criteria when implementing screening, brief interventions and support for hazardous, harmful and dependent drinkers.</p>	<p>PCTs and their partners take account of different needs and inequalities within the hazardous, harmful and dependent drinkers population, in respect of area, socio-economic group, ethnicity, gender, disability, age, faith, and sexual orientation, on the basis of a systematic programme of health equity audit and equality impact assessment. This should address issues of race equality.</p> <p>Health equity audits identify how fairly services or other resources are distributed in relation to the health needs of different groups. By using evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery, health equity audits can help organisations address inequalities in access to services and in health outcomes, such as the inequalities experienced by black and minority ethnic groups.⁴⁸</p>

Local Action: guidance for PCTs	
Principles for planning and commissioning	Practical steps that PCTs can take
Evidence-based	In order to set local priorities, PCTs and their partners will want to consider findings from ANARP, MoCAM and the Review of Effectiveness of Treatment for Alcohol Problems.
Partnership	<p>Successful modernisation and improvement depend on PCTs, local authorities, other local partners, service users and service providers, including those from the independent sector and voluntary organisations working together.</p> <p>Those PCTs setting local targets to implement screening, brief interventions and treatment for hazardous, harmful and dependent drinkers can agree these with local authorities and other partners.</p>
Offer value for money	Match provision with assessed need and ensure best value. Existing contracts, particularly with NHS Trusts, may need to identify alcohol costs within larger contracts to facilitate this. Existing contracts may need to be re-negotiated when practicable but better services will not necessarily mean new providers.
Developing the workforce	<p>Developing local capacity and capability:</p> <p>As stated in <i>National Standards, Local Action</i> – whilst no detailed workforce targets for local organisations are being set, Local Delivery Plans will be expected to demonstrate that robust workforce plans are in place to support delivery of national targets through increases in the size of the workforce, roll-out of new ways of working and improvements in workforce productivity.</p> <p>This will be facilitated by new GP and consultant contracts, by Agenda for Change and by the extra capacity available from new independent sector providers.</p> <p>Workforce development and service redesign will also be underpinned by strengthening commitment to lifelong learning and skills enhancement for staff at all levels.</p>
It will be important to engage with the programme to deliver the workforce elements of <i>Choosing Health</i> .	

Annex D: Regional support

<p>Regional support</p>	<p>As part of DH the nine RDsPH and their RPHGs are co-located in each of the nine regional GOs. They provide leadership for the cross-government work on implementing policy on wider determinants of health and will oversee the performance of DH's cross-government programmes and networks supporting wider determinants of health and the reduction of inequalities, including the <i>Choosing Health</i> commitment to reduce the harm caused by hazardous, harmful and dependent drinking and encourage sensible drinking.</p> <p>There are nine Public Health Observatories (PHO), one in each region in England. The purpose of the PHOs is to:</p> <ul style="list-style-type: none"> • Strengthen the availability and use of information about health at regional and local level; • Strengthen the flow of information and data to support public health input into the broad range of cross-government initiatives aimed at improving health and reducing inequalities. <p>In addition, PHOs are expected to be linked together to form a national network of knowledge, information and surveillance in public health.</p> <p>Government Offices have a lead role in improving the functioning of crime and drugs partnerships and in supporting less well performing partnerships</p>
	<p>Beginning in January 2006 DH will hold nine regional conferences, in partnership with the DH RDsPH, to discuss the emerging evidence and practice on screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.</p>
	<p>DH RPHGs will ensure an effective regional intelligence and information function through the PHO that supports the availability of regional and local information on health, for local people, the NHS, regional and local partners. This will include reports on health where requested by regional bodies.</p> <p>Existing regional and PHO work on alcohol related health will be supported by the regional information from ANARP. This can be used by PCTs to help determine local levels of hazardous, harmful and dependent drinkers and to identify gaps in local provision in line with MoCAM.</p> <p>A web-based tool will be available from December 2005 and will be further developed with assistance from the North West PHO.</p>
	<p>DH RPHGs will lead the development and implementation of regional frameworks to reduce the harm caused by hazardous, harmful and dependent drinking and encourage sensible drinking through work in partnership with regional assemblies, GOs and Regional Development Agencies.</p>
	<p>DH RPHGs will support reducing the harm caused by hazardous, harmful and dependent drinking and encouraging sensible drinking by fostering closer working between GOs and SHAs. They will work with SHAs to ensure the NHS contributes effectively to local partnerships such as LSPs and CDRPs and partnership agreements such as LAAs.</p>
	<p>DH RPHGs will identify regional alcohol related issues and concerns that may need a national policy response and broker support for local action and facilitate cross regional learning and development opportunities.</p>
	<p>DH RDsPH represent DH in the LAA process supported by SHAs.</p>
	<p>GO performance manage specific Home Office projects delivered through crime and drugs partnerships (such as the Tackling Violent Crime Programme which focuses on alcohol and domestic violence).</p>

Annex E: National support

National support	
<p>Financial commitment</p> <p>Additional funding provided to augment existing investment from mainstream budgets.</p>	<p>PCTs have been notified that £15m per annum will be included within the PCTs' general allocation from 2007/8 onwards to 'help PCTs to improve their local arrangements for commissioning and delivering alcohol interventions' (9 February 2005 – AWP(06-07)PCT01).</p>
<p>Screening and brief intervention Trailblazer projects (from Spring 2006)</p>	<p>Research evidence on screening and brief interventions indicates that many individuals benefit from brief interventions. However, in order to strengthen the UK evidence base, Trailblazer projects will be taking place to determine the impact of targeted screening and brief interventions in different settings, e.g. primary care, hospital and criminal justice settings. The projects will also identify the best screening tools and best intervention methods tailored to these various settings.</p> <p>These projects will begin in Spring 2006 and the final report will be provided by Summer 2008. However, the projects will release interim findings as they emerge and produce formal six-monthly progress reports, which will be available to stakeholders.</p>
<p>The Alcohol Needs Assessment Research Project (ANARP) (2005)</p>	<p>Publication of the key findings from ANARP provides a national and regional analysis of the full range of alcohol-related demand and current provision (November 2005).</p> <p>Regional information from ANARP can be used to help determine local levels of hazardous, harmful and dependent drinkers and support PCTs to identify gaps in local provision in line with MoCAM. A web-based tool will be available from December 2005 and will be further developed with assistance from the North West PHO.</p> <p>ANARP found:</p> <ul style="list-style-type: none"> • 32% of men and 15% of women are hazardous or harmful alcohol users. This equates to 7.1 million people in England. • 21% of men and 9% of women are binge drinkers. • 6% of men and 2% of women are alcohol dependent. This equates to 1.1 million people in England. • BME groups have a considerably lower prevalence of hazardous/harmful alcohol use but a similar prevalence of alcohol dependence compared to the white population.
<i>continued</i>	

<p>National support</p>	<p>ANARP found regional variations in alcohol-related need:</p> <ul style="list-style-type: none"> • The prevalence of hazardous/harmful drinking varied from 18% (Eastern region) to 29% (North West region). • Alcohol dependence ranged between regions from 1.6% (East Midlands) to 5.2% (North East and Yorkshire and Humber). • Regions with the highest prevalence of hazardous/harmful drinking are different from those with the highest prevalence of alcohol dependence. <p>ANARP found extremely low levels of formal identification, treatment, and referral of patients with alcohol use disorders by GPs:</p> <ul style="list-style-type: none"> • GPs formally identified approximately 1 in 67 male and 1 in 82 female hazardous/harmful drinkers. • The formal identification rate by GPs for alcohol dependence was 1 in 28 and 1 in 20 for males and females respectively. • GPs tended to under-identify young patients with alcohol use disorders compared to older patients. • There was considerable regional variation in the identification of alcohol-related disorders, with Yorkshire and Humber and London having the lowest formal identification rates for both hazardous/harmful drinking and dependence. This was 3–4 times less than the identification rate in the best performing regions. <p>ANARP identified 696 alcohol-related services and revealed that the voluntary sector delivers over half of all alcohol services.</p> <p>The largest proportion of referrals to alcohol agencies are self referrals (36%), followed by GP and primary care referrals (24%).</p>
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<p>National support</p>	<p>Models of Care for Alcohol Misusers (MoCAM), DH and NTA (From late 2005)</p>	<p>MoCAM provides a framework and sets criteria that PCTs can use for the commissioning and provision of local alcohol treatment systems to address the needs of adults identified as being hazardous, harmful or dependent drinkers.</p> <p>MoCAM includes guidance on developing comprehensive local integrated pathways for alcohol treatment, including pathways for those in vulnerable circumstances, such as people with mental illness, rough sleepers and drug users.</p>
<p>The Review of the Effectiveness of Treatment for Alcohol Problems, NTA (From late 2005)</p>	<p>The <i>Review of the Effectiveness of Treatment for Alcohol Problems</i> will be published alongside MoCAM, together with a summary document detailing key findings. The summary is sufficient to inform Chief Executives and other senior managers in SHAs, PCTs, local authorities and other partners. Commissioners, service providers and others with a significant role or interest in alcohol-related issues should be advised to consult the full review document, which will act as a key reference work in the coming years.</p>	
<p>Communications Plan for Health Professionals</p>	<p>As part of a wider, cross-government alcohol harm reduction communications plan, a comprehensive communications programme is being developed to help NHS organisations, local authorities, criminal justice agencies, service providers, the independent sector, voluntary organisations, service users and other partners to learn about the programme of improvement to develop alcohol misuse interventions.</p> <p>The communications programme aims to be flexible and easily tailored at a local level.</p> <p>Two-way communication is at the heart of the plan, including government departments and stakeholder networks talking and listening to each other.</p>	
<p>A Study: Building Service User's Perspective</p>	<p>A review of the experiences of service users, help seekers and ex-service users is being carried out to help identify the supports and obstacles they face. This will be useful in developing the ability of the alcohol treatment sector to involve service users in planning, commissioning and treatment delivery.</p>	

<p>National support</p>	<p>Workforce It will be important to engage with the programme to deliver the workforce elements of <i>Choosing Health</i>.</p> <p>Undergraduate Medical Curriculum Project</p> <p>Postgraduate training</p> <p>Regional conferences</p>	<p>We will engage with the national workforce strategy and competency framework, to underpin the development of education and skills and work across the health and social care community, local government, business communities and the voluntary sector.</p> <p>We will engage with Skills for Health to ensure that alcohol issues are considered in the training of the health workforce where appropriate as indicated in <i>Choosing Health</i>.</p> <p>DH has commissioned the International Centre for Drug Policy (ICDP) to undertake a project aimed at scoping current substance misuse training and gaining a consensus approach to enhancing training across the medical schools.</p> <p>The project will produce a toolkit reflecting this consensus approach which will include a module on alcohol.</p> <p>DH is currently exploring a similar project for pre-qualifying nurse education curricula.</p> <p>DH will work with stakeholders to identify appropriate postgraduate training on alcohol for GPs and practice nurses.</p> <p>Beginning in January 2006 DH will hold nine regional conferences, in partnership with DH RDsPH, to discuss the emerging evidence and practice on screening, brief interventions and treatment for hazardous, harmful and dependent drinkers.</p>
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Annex F: Practice examples

1. Primary Care

Studies in the UK by Wallace, Cutler & Haines (1988) and by Anderson and Scott (1992) established the effectiveness of brief interventions delivered by general practitioners in reducing the proportion of patients drinking above medically-recommended guidelines. The public health potential of GP-based brief interventions was highlighted by Wallace *et al* when they estimated, on the basis of their findings, that routine and consistent implementation of their intervention program by general practitioners throughout the United Kingdom would result in a reduction from hazardous or harmful to low-risk levels of the drinking of 250,000 men and 67,500 women each year.

2. WHO Implementation Project in North East England

Researchers in the North East of England are leading work on disseminating evidence about brief alcohol intervention in primary care and on promoting its use in routine practice. Two large trials with GPs and primary care nurses have been run as part of a WHO Collaborative study. Initially, social marketing techniques (mail, telephone and personal marketing) were used to encourage GPs to take brief intervention materials. Although promotional leaflets encouraged a fifth of GPs to take brief intervention materials and agreed to try them, more direct approaches such as telemarketing or personal visits to the practice were more effective (60-80%).

Once GPs and nurses had agreed to try implementing a brief intervention programme, a combination of written guidance, practice-based training and telephone support calls were used to encourage actual use. For GPs and nurses, written guidance was less effective at promoting brief intervention than a one-hour practice-based training; further telephone-based support encouraged GPs further but not nurses.

Within these trials, in a 3-month period, GPs screened over 12,000 patients and identified 4,080 'at risk' drinkers. In a similar time period, nurses screened 5,500 patients and identified 1,500 'at risk' drinkers. Most of the patients who had an increased risk to their health because of their drinking were given 5 minutes brief intervention. However, some groups of risk drinkers were less likely to receive brief intervention than others.

Thus GPs were less likely to deliver brief intervention to females, students and university educated patients. Nurses were least likely to deliver brief intervention to female patients.

3. Tyne and Wear Health Action Zone – Screening and Brief Intervention Demonstration Project

Gateshead PCT, funded by the Tyne and Wear Health Action Zone, has been working intensively with five practices to tailor elements of screening and brief alcohol intervention to 'real world' primary care. The aim of this project was to fine-tune tools, protocols and training, using a plan-do-study-act approach.

This work has resulted in an updated brief intervention programme called 'How much is too much?' and training materials specifically designed for use in primary care.

4. Dudley Borough Alcohol Arrest Referral Scheme

This arrest referral scheme is operated by Aquarius, a voluntary-sector organisation who operate a local Community Alcohol Team. The core purpose of the scheme is to deliver brief interventions to non-dependent drinkers whose drinking is linked to criminal or anti-social behavior. This is in contrast to how most drug arrest referral schemes operate, as these tend to engage with drug users and refer them into treatment.

The Dudley scheme is delivered by skilled alcohol counsellors using motivational interviewing approaches to help the recipients make the link between their drinking and their offending.

5. Conditional Cautioning

On 1 September 2005 the first Conditional Cautions Referral Scheme for alcohol-related offending was launched in Preston. The scheme aims to provide an alternative to prosecution where the offending is alcohol related and involves the offender attending a session on the problems associated with alcohol misuse. The offender would usually be required to bear the cost of the scheme (£30). It is likely that a significant number of offenders attending the scheme will have committed public-order offences related to irresponsible drinking. The scheme is being evaluated by the PCT and local alcohol and drugs services.

A number of other areas have shown an interest in the scheme and they view it as a valuable alternative to the court process. This view is supported by the Conditional Cautions Project Team and Crown Prosecution Service (CPS) who recently conducted a limited review of cases in Newcastle. They found that approximately 50% of Magistrates Courts early guilty plea cases that resulted in a low-level fine, a small amount of compensation and/or a discharge were for Drunk & Disorderly. The cost implication would be relatively light, as the Preston model requires attendees to pay to attend the course, and it is therefore more or less self-funding.

6. **St Mary's Hospital London Model**

Screening and referral for brief intervention of alcohol-misusing patients in an emergency department: a pragmatic randomised controlled trial that took place in St Mary's Hospital Emergency Department

St Mary's Hospital London Model: The A&E Department, under the leadership of their Consultant, Dr Robin Touquet, have developed a screening tool specifically designed for their environment, the Paddington Alcohol Test (PAT). All patients presenting to A&E with one of the targeted conditions are screened for hazardous or harmful drinking. If positive for hazardous or harmful drinking, patients are offered the opportunity to have a session with the A&E's alcohol health worker within 24 to 48 hours. This worker is a trained nurse who carries out a more in-depth assessment concerning the individual's lifestyle and alcohol use. The worker then delivers a brief intervention of education and counselling concerning the patient's use of alcohol.

A recent report in the *Lancet* on this project reports that those who received this intervention made an average of 0.5 fewer visits to A&E during the following 12 months.⁴⁹

7. **The Royal Liverpool Hospital – Lifestyles Team**

The Lifestyles Team arose out of the recognition that alcohol attendances and admissions placed a large burden on the Royal Liverpool Hospital. Indeed, 12% of A&E attendances and one-third of admissions to Intensive Treatment Units (ITU) were directly attributable to alcohol.⁵⁰

One Alcohol Specialist Nurse is employed within the hospital trust to respond to alcohol-related referrals from A&E, clinics and ward areas throughout the hospital. The main aims of the model are to:

1. Optimise medical management of alcohol-related attendance and admissions.
2. Provide patients with timely appropriate and effective clinical pathways of care.
3. Reduce overall alcohol-related hospital admission and attendance.
4. Reduce length of stay for alcohol-related admissions.

In addition to the Specialist Nurse who concentrates on A&E and other hospital wards, the team also have two nurses who support alcohol interventions by GPs in the primary care setting.

8. Local joint initiatives planned in partnership

In order to make more effective use of police and health resources, some local schemes have developed joint initiatives whereby triage services are made available away from A&E and closer to hotspots for alcohol-related disorder.

9. Kent DAAT Joint Commissioning Team

Kent DAAT established a joint commissioning team with 3 PCTs having a lead role and representing 9 PCTs in their area. They also established quarterly meetings with Crime and Disorder Reduction Partnership (CDRP) officers and Chairs of the Drug and Alcohol CDRP sub groups to ensure that joint planning is established and information is exchanged.

The DAAT produces a quarterly statistical bulletin that contains information on numbers accessing treatment, numbers, types and location of arrests, hospital admissions data and A&E data (East Kent only) as well as other sources of data. This is an extremely useful planning tool.

10. North East Alcohol Group

In the North East, an Alcohol Group has been set up to collectively address the problems highlighted in the Alcohol Harm Reduction Strategy and Choosing Health and to identify what can be done at a regional level to add value to local and national work.

The Group has a wide membership with representatives from the health sector, police, service users, trading standards, the industry and regional agencies. This reflects the ethos of the Alcohol Harm Reduction Strategy in facilitating partnership working to tackle alcohol misuse.

The key principles of the Alcohol Group's action plan are to consider appropriate education methods; find out what initiatives are currently in place; information gathering and identification of available sources of funding.

The actions include awareness raising of the problems relating to alcohol misuse and an information subgroup is collating local data both to inform practitioners and strategy development and also to identify good practice which can be disseminated by the Group.

Annex G: The policy context

1. **Alcohol Harm Reduction Strategy for England** (published March 2004) has four themes:
 - improved education and communication;
 - better identification and treatment;
 - alcohol-related crime and disorder; and
 - supply and industry responsibilities.

2. **Choosing Health – making healthy choices easier** (published November 2004) highlights action on reducing alcohol-related harm and encouraging sensible drinking as one of its six priorities and places alcohol firmly in the realm of public health practice.
 - 2.1 *Choosing Health* emphasises and builds on the recommendations in the *Alcohol Harm Reduction Strategy for England*. It proposes to reduce harm and encourage sensible drinking by:
 - a national information campaign to tackle the problems of binge drinking;
 - a social responsibility scheme;
 - training for professionals;
 - piloting screening and brief interventions in primary and secondary health settings, including A&E;
 - similar pilots in criminal justice settings; and
 - a programme of improvements for treatment services.

3. **The Crime and Disorder Act 1998** (as amended by the Police Reform Act 2002)
 - 3.1 PCTs in England became “responsible authorities” under the Crime and Disorder Act 1998, amended by the Police Reform Act 2002, on 30 April 2004. This means that now PCTs have a statutory responsibility to work in partnership with other responsible authorities, namely the police, fire and local authorities and co-operating bodies to tackle crime, disorder and the misuse of drugs.

- 3.2 Over a three-year cycle, the act places a duty on PCTs to:
- participate in an audit of crime and disorder, anti-social behaviour and drug misuse for the *Crime and Disorder Partnership* (CDRP) area or areas in which they fall; and
 - contribute to the development of local strategies that effectively deal with the issues which are identified.
- 3.3 The first audit in which PCTs participated was completed by the end of September 2004 and after consultation with local communities the local CDRP was required to published their strategy by April 2005. The strategy will last for three years.
- 3.4 The extent to which the PCT is involved in the delivery of the strategy is not specified. In practice this will be determined through local negotiation and it is likely to be greatest in areas where the delivery of action on drugs, alcohol and crime and disorder makes a significant contribution to the PCT's own national or local priorities.
- 3.5 Action in support of the local Crime and Disorder Strategies may impact positively on a range of national NHS priorities, including:
- reducing health inequalities;
 - positive patient satisfaction;
 - positive staff satisfaction;
 - improvement in the life chances for children;
 - increasing the participation of problem drug users in treatment;
 - implementation of the National Service Framework for Mental Health; and
 - reductions in waiting times.
- 3.6 *The Tackling Violent Crime Programme (TVCP)*, launched by the Home Office in November 2004, is one of the programmes funded and delivered through crime and drugs partnerships. TVCP targets the highest violent crime areas only and focuses on domestic violence and alcohol-related violence. (The British Crime Survey shows that 47% of victims described their assailant as being under the influence of alcohol.)

- 3.7 Local crime and drugs partnerships work to deliver the Young People's Substance Misuse Prevention Agenda and local authorities hold the Young People's Partnership Grant on behalf of the partnership. There is a particular emphasis on targeted young people high focus areas.
4. **The Licensing Act 2003** is intended to provide:
- a clear focus on the prevention of crime and disorder;
 - a clear focus on public safety;
 - the prevention of public nuisance; and
 - the protection of children from harm.
- 4.1 PCTs are not responsible authorities under this act and local Licensing Committees are not required to consult with PCTs when granting licenses. Licensing Committees are required to consult with crime and drugs partnerships and PCTs can make their views and recommendations known through their crime and drugs partnerships.
- 5 **Respect agenda**
- 5.1 A new cross-governmental Respect Task Force with direct responsibility for delivering the Respect agenda will be based in the Home Office and report to the Home Secretary.
- 5.2 An inter-ministerial steering group will include ministerial and official representation from across the Government, including the Office of the Deputy Prime Minister, Department for Education and Skills, Department for Culture Media and Sport, Department of Health, Department for Work and Pensions and Department for Environment Food and Rural Affairs, as well as external expert advisers.
- 5.3 The key objective of the new unit will be to drive forward the Respect agenda including:
- Working together on the neighbourhood renewal and anti-social behaviour agendas, highlighting respect for others and respect for the community.
 - Supporting parents and guardians to build their skills and accept responsibility for the impact that the behaviour of their children has on others.

- Encouraging respect for public servants and services including teachers and schools, health and emergency services and the police.
- Supporting the neighbourhood policing, police reform and alcohol and violent crime strategies.
- Ensuring the culture of respect extends to everyone, young and old alike.
- Helping communities to set and own standards of behaviour in their neighbourhoods.

6. **Every Child Matters**

- 6.1 This white paper focuses on supporting all children, particularly those in the vulnerable groups, to have better outcomes as adults. Substance misuse, including alcohol, is an important element of this.

7. **Local Strategic Partnerships (LSPs)**

- 7.1 In the interests of strong multi-agency working, a PCT will commonly agree its shared objectives with local authorities and other partners through LSPs.

8. **Local Area Agreements (LAAs)**

- 8.1 LAAs are an important new type of planning process that brings health inequalities and health outcomes to the forefront of local community planning. LAAs are negotiated and agreed by regional GO staff on behalf of the Government. DH RDsPH represent DH in this process supported by SHAs; SHAs also have a role to agree the PCT contribution to the LAA and in supporting PCTs to deliver health improvements.
- 8.2 Outcomes are negotiated between local authorities (and their partners) and GOs on behalf of central departments. LAAs reflect both local and national priorities. PCTs are responsible for leading the development and delivery of the health elements of LAAs, with the support and encouragement of SHAs.

- The health and social care input in phase two LAAs (from April 2006) is focused on public health and on services to adults at the interface between health and social care agencies.
- For phase two LAAs there is a need to ensure that LAAs' proposals are consistent and aligned with already agreed Local Delivery Plans (LDPs), through local targets or agreed contributions to national priorities.
- There should be scope for the LAA to build on the LDP, for example by identifying joint action to tackle the wider determinants of health such as the reducing alcohol harm and encouraging sensible drinking priority identified in *Choosing Health*.

8.3 Spearhead PCTs have been set particularly challenging targets to reduce health inequalities in their area. Through the LAAs process PCTs can engage the local authority and other local partners in the co-delivery role described in the *Choosing Health* white paper.

9. **Creating a Patient-led NHS**

9.1 The NHS now has the capacity and the capability to move on from being an organisation which simply delivers services to people to being one which is totally patient led – responding to their needs and wishes.

9.2 Every aspect of the new system is designed to create a service which is patient led, where:

- people have a far greater range of choices and of information and help to make choices;
- there are stronger standards and safeguards for patients; and
- NHS organisations are better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction.

9.3 In order to be patient led the NHS will develop new service models which build on current experience and innovation to:

- give patients more choice and control wherever possible;
- offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high-quality care; and

- make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.

9.4 The NHS will also develop the way it secures services for its patients. It will:

- promote more choice in acute care:
 - PCTs will be responsible for making sure that from 2006 they offer choices to patients;
 - PCTs will not need to direct patients to particular providers but will offer a choice of four or five local NHS providers, together with all NHS Foundation Trusts and nationally procured Independent Sector Treatment Centres;
 - all other independent sector providers may apply to be on the list of choices for patients, if they are able to operate to NHS standards and at the NHS tariff;
- encourage primary and community services to develop new services and new practices;
- strengthen existing networks for emergency, urgent and specialist services, with PCTs and SHAs having explicit responsibility to review and develop them;
- build on current practice in shared commissioning with the aim of creating a far simpler contract management and administration system which can be professionally managed and provide better analysis while leaving practices and PCTs in control of decision making; and
- concentrate more on health improvement and developing local patient pathways and services.

9.5 The NHS needs a change of culture as well as of systems to become truly patient led, where:

- everything is measured by its impact on patients;
- the NHS is as concerned with health promotion and prevention – looking after the whole person – as with sickness and injury; and
- the staff directly looking after patients have more authority and autonomy, supporting the patient better.

This will require:

- action to tackle the barriers which create rigidity and inflexibility in the system;
- shared values and codes of conduct, enshrining the desired changes in culture;
- greater support of frontline staff and clinical leadership;
- continuous learning, supported by the new NHS Institute for Learning, Skills and Innovation;
- a new model for managing change suitable for the new environment; and
- clearer leadership at all levels, integrated nationally through the new National Leadership Network for Health and Social Care.

9.6 A patient-led NHS needs effective organisations and incentives, with:

- a new development programme to help NHS Trusts become NHS Foundation Trusts;
- a similar structured programme to support PCTs in their development;
- further development of payment by results to provide appropriate financial incentives for all services;
- greater integration of all the financial and quality incentives; and
- full utilisation of the new human resources and IT programmes.

9.6.1 Change on this scale involves uncertainty and all organisations need to plan to manage the risks with some national support to:

- strengthen the role of the NHS Bank;
- improve the way the NHS handles service and organisational failure; and
- improve the way that service change and reconfiguration is managed.

Annex H: Associated documents

Department of Health www.dh.gov.uk

- *Choosing Health: Making Healthy Choices Easier*
- *The Alcohol Needs Assessment Research Project (ANARP) (2005)*
- *National Standards, Local Action: Health and Social Care Standards and Planning framework 2005/06-2007/08*
- *Tackling Health Inequalities, a Programme for Action*
- *The NHS Cancer Plan, a Plan for Investment, a Plan for Reform*
- *Coronary Heart Disease, National Service Framework*
- *Guidance for partnerships and primary care trusts (PCTs): Commencement of PCTs as responsible authorities from 30 April 2004*
- *Models of Care for Alcohol Misusers (MoCAM) (DH, NTA) (when published)*
- *The Review of the Effectiveness of Treatment for Alcohol Problems Summary (NTA) (when published)*
- Spearhead PCTs
- Department of Health Alcohol Website: www.dh.gov.uk/alcohol

Home Office www.homeoffice.gov.uk

- Crime and Disorder Act 1998 and Police Reform Act 2002
- The Respect Agenda
- Crime and Disorder Reduction Partnerships
- Alcohol Related Crime
- Drinking Responsibly
- Violent Crime (including domestic violence)
 - Violent Crime Reduction Bill

Department of Culture, Media and Sport www.culture.gov.uk

- The Licensing Act 2003

Office of the Deputy Prime Minister www.odpm.gov.uk

- *'How to' Guide* on engagement for integrated partnerships in respect of crime, alcohol and drugs
- Local Strategic Partnerships
- Local Area Agreements guidance

Prime Minister's Strategy Unit www.strategy.gov.uk

- *The Interim Analytical Report – The evidence base for the Alcohol Harm Reduction Strategy*
- *The Alcohol Harm Reduction Strategy for England*

Department for Education and Skills www.dfes.gov.uk

- Every Child Matters

Health Development Agency www.hda-online.org.uk**Health and Safety Executive** www.hse.gov.uk

- Guides to alcohol and employment

Alcohol Concern www.alcoholconcern.org.uk

- Local Alcohol Strategies Toolkit www.localalcoholstrategies.org.uk

National Treatment Agency www.nta.nhs.uk**NHS Direct** www.nhsdirect.nhs.uk**Department of Health Substance Misuse Team** alcoholquery@dh.gsi.gov.uk

- For general enquires on DH alcohol policy

Annex I: Glossary

A&E	Accident and Emergency (department)
ANARP	Alcohol Needs Assessment Research Project
AUD	Alcohol Use Disorder
BME	Black and Minority Ethnic (groups)
CDRP	Crime and Disorder Reduction Partnership
CPA	Comprehensive Performance Assessment
CPS	Crime Prosecution Service
DAAT	Drug and Alcohol Action Team
DALYs	Disability-adjusted life years
DfES	Department of Education and Skills
DH	Department of Health
DPH	Director of Public Health
DWP	Department for Work and Pensions
GMS	General Medical Services
GO	Government Office
GP	General Practitioner
HCC	Healthcare Commission
ICDP	International Centre for Drug Policy
ITU	Intensive Treatment Unit
LA	Local Authority
LAA	Local Area Agreement
LDP	Local Delivery Plan (NHS)
LSP	Local Strategic Partnership
MoCAM	Models of Care for Alcohol Misusers

NHS	National Health Service
NICE	National Institute of Clinical Excellence
NIMH(E)	National Institute of Mental Health (England)
NOMS	National Offender Management Service
NSPCC	National Society for the Prevention of Cruelty to Children
NTA	National Treatment Agency
ODPM	Office of the Deputy Prime Minister
ONS	Office of National Statistics
PAT	Paddington Alcohol Test
PCT	Primary Care Trust
PHO	Public Health Observatory
PSA	Public Service Agreement
RDPH	Regional Director of Public Health
RPHG	Regional Public Health Group
SHA	Strategic Health Authority
STD	Sexually Transmitted Disease (clinic)
TVCP	Tackling Violent Crime Programme
UKATT	United Kingdom Alcohol Treatment Trial
WHO	World Health Organization

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271232 1p 2.5k Nov05 (CWP)

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