Tackling the UK’s alcohol problems

A new UK unit, which takes alcohol-dependent patients straight out of the emergency setting to a specialist detox centre, is a promising approach, say experts. Nayanah Siva reports.

“I’m in no state, I miss so many appointments when I’m drinking—doctors, dentists, ADS [the alcohol and drug service]. All I do is drink, nothing outside that window matters to me when I drink, when I really get into it.”

This is Jack (name changed) who was a patient at a specialist rapid alcohol detox unit in Manchester, UK. RADAR (rapid access to alcohol detoxification acute referral) is the first service in the country to take patients from different accident and emergency (A&E) departments (11 across Greater Manchester) to a specialist centre for immediate detox therapy. A report by researchers at Liverpool John Moores University published earlier this year estimates that the unit could save the National Health Service (NHS) £1.3 million per year.

The snapshot of Jack’s life shows the deep complexity of treating alcohol misuse problems. “People with chronic and severe alcohol dependence can become trapped in a cycle of heavy drinking, and drinking to avoid withdrawal symptoms that is absolutely miserable and hard to treat”, explained John Marsden, professor of addiction psychology at King’s College London, UK.

Alcohol misuse is associated with many diseases and disorders including heart disease, stroke, liver disease, and cancer, and is currently costing the NHS £3.5 billion a year. In addition, the cost to society is in the region of £25 billion. “Problem alcohol use is a major public health concern as it is associated with a wide range of adverse health and social outcomes including alcohol poisoning, unintentional injury, violence, and sexual assault”, states the report. The report noted that alcohol-related presentations to hospital continue to increase in the UK, with one of the major causes of hospital admissions being withdrawal symptoms.

RADAR recognises the impact of dealing with long-term alcohol misuse in the emergency setting and its main aims are to reduce the burden on acute trusts, improve clinical experience and outcomes for patients, and demonstrate cost-effectiveness. RADAR runs a personalised 5–7 day detoxification programme with a strong focus on engagement and aftercare planning to prevent relapse. “The difference in RADAR is the emergency/urgent admission deflecting patients away from the general hospital to a specialist facility at a time of crisis where they can receive evidence-based treatment focused on their alcohol dependence”, said Chris Daly, lead consultant in substance misuse at RADAR, Chapman-Barker Unit, Prestwich Hospital. “We are tapping into the concept of there being a treatable moment, and the fact that intervention in a crisis can work…”

Alcohol misuse behaviours

Several types of alcohol misuse behaviour exist. “Most of this cost burden on the NHS does not actually all come from alcohol-dependent people”, Mike Ward, consultant for Alcohol Concern, pointed out. “There is this middle group of drinkers, who drink more than is good for them on a regular basis but not in the classically dependent manner.”

Sarah Hughes, consultant hepatologist and clinical lead for the alcohol care team at St George’s Hospital, London, runs through the spectrum of problem drinking behaviour. “There are the entrenched dependent street drinkers, often frequent attenders to A&E (and readily seen as a burden on NHS resources), to headline-hitting young binge drinkers, to the rising numbers of people who drink consistently above ‘safe’ drinking levels at home.” Surprisingly, Hughes said she was most concerned about this third group, who are often older and may present less often to acute NHS services but may increasingly visit outpatient, and ultimately inpatient secondary care with liver fibrosis, cirrhosis, and complications of chronic liver disease.

The number of people in this third group and the number with more severe alcohol dependence is increasing in the UK. “The status has not improved”, explained Roger Williams, director of the Institute of Hepatology, London, and director of the Foundation for Liver Research. “There are still large numbers of people being admitted to hospital with acute alcoholic liver damage. And the mortality rates are still very high.”

Liver disease is the only major cause of mortality and morbidity that is on...
the rise in England while decreasing in other European countries.

Marsden thinks one of the key approaches is to identify alcohol misuse as early as possible. “But the challenge is twofold: on the one hand, many health and social care professionals are reluctant to ask people questions about drinking and opportunities to help people make changes early are missed”, said Marsden. “And on the other hand, we all need to appreciate that a chronic drinking problem is going to need sustained treatment of sufficient intensity and duration to tackle entrenched habits.”

**Resources and training**

“What is an awful statistic is that less than 25% of district general hospitals have an alcohol team in place”, said Williams. “So in 75% of hospitals there is no expertise or facilities available when treating patients with alcohol problems.” Williams noted that A&E alcohol admissions account for nearly 25% of admissions on most days, except Saturdays when the percentage is even higher. “There are not enough consultant hepatologists and there is very little knowledge of alcohol problems in general practice and very little interest by GPs [general practitioners] in diagnosing early alcoholic liver disease and managing it.”

But Hughes is optimistic and thinks the situation is slowly changing. She explained that in the past there was a lack of joined-up transition for patients between primary and secondary care providers. “We are very good now at using this multidisciplinary team approach to managing patients and services.” Hughes describes the use of Fresh Start Clinics, which are GP-led facilities with dedicated alcohol and drug health workers, and they address mild-to-moderate stable, dependent drinkers. But Hughes acknowledges that trying to bridge the gap between hospital and community has logistical challenges and she thinks this has been one of the barriers to implementing effective patient-centred alcohol services.

**Personalised care**

Alcohol misuse is a very different condition to drug addiction and experts think it is important that this is recognised. Only 6% of adults with alcohol dependence receive treatment compared with around 50% of serious drug users. “One of the big reasons for that is we have seen a pressure on alcohol services from commissioners to meet outcome targets for drinkers, which I think is unrealistic”, said Ward. “They are expecting people to get better very quickly...we need services which are able to work with people for longer periods of time and are able to be more assertive in their approach.”

“We need government action to make alcohol more costly because it has been shown the whole world over that the amount of alcohol a country consumes is related to its overall cost’...”

But therapy is not always successful with this patient population. Gordon Hay, reader in social epidemiology at the Centre for Public Health, Liverpool John Moores University, and an author on the report, pointed out that patients who visited RADAR did not always achieve abstinence. “Some of the patients continued to drink and experience alcohol-related harm but the research [of the RADAR clinic] showed that treating this group of patients is cost effective even when not 100% successful.”

Experts say it is important to understand patients and try to personalise care. “We need defined pathways of management for patients with alcohol dependence and an understanding that the needs of patients will vary”, said Hughes. Effective treatment options have improved and now have a strong evidence base, noted Marsden. He mentioned underused drug therapies that GPs and specialists have available that can help patients reduce the reinforcing (pleasurable) effects of alcohol, such as naltrexone, acamprosate, and nalmefene. “I believe substantially more people who are struggling to reduce heavy drinking could benefit from these medications.”

**Government action**

But the recurring theme among all experts was the need for government action. “Treatment alone may not suffice, therefore controls on pricing, marketing, and availability of alcohol may also be required in order to reduce alcohol-related harm and costs to the NHS”, said Hay.

“We need government action to make alcohol more costly because it has been shown the whole world over that the amount of alcohol a country consumes is related to its overall cost”, emphasised Williams. A minimum price per unit of alcohol would make the cheapest alcohol 45–50 p per unit and this targets the heavy drinkers, “those who drink 100 units a day”, he said.

Williams is also concerned about how readily available alcohol is in this country. “People can go into supermarkets any time of day and night to buy cheap alcohol. And the legal drink-driving limit needs to be reduced in line with the rest of Europe”, said Williams.

**On the right track**

But experts welcome the new approach of RADAR and hope similar systems will be rolled out across the UK. “Anything that helps people in this situation to get to grips with their drinking, rather than being patched up and discharged, has got to be a good thing”, said Andrew Misell, director of Alcohol Concern. And its not just experts, clinicians, and social workers who think RADAR’s method is helpful. “I got a bit of hope that I could sort something out”, one patient being treated at RADAR told The Lancet.

Nayanah Siva