



“Missed opportunities”

Five steps to preventing and reducing alcohol related physical health harm

***A Recovery Partnership project
to review and improve the generic and specialist
response to alcohol related illness and disease***

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The Recovery Partnership was set up with the support of the Department of Health to be *"a new collective voice and channel for communication to Ministers /Government on the achievement of the ambitions in the drug strategy."* It has promoted the treatment and recovery voice in the drug and alcohol field.

This specific project was funded by the Department of Health in England to consider alcohol related health harm.

Executive summary

Alcohol related illness and disease costs the NHS £3.5 billion per annum and the burden is increasing every year. Beyond the cost, each alcohol related death is a tragedy. Yet some very simple strategies can reduce this impact.

The Recovery Partnership has undertaken some original research and drawn on other recently published sources of evidence to identify five missed opportunities to reduce the damage to individuals and the impact on health services.

1. **Improving the physical effects training of non-medical alcohol service staff:** 60% of non-medical specialist alcohol workers have had less than one day's training on the physical effects of alcohol
2. **Challenging the stigmatisation of problem drinkers in generic healthcare and other services:** problem drinkers experience prejudice when entering healthcare (and other services)
3. **Educating families to identify health problems:** families and carers are an untapped resource in recognising health symptoms at the earliest opportunity and supporting engagement with health services
4. **Disseminating a symptoms based identification tool like the 12 questions:** a tool from Alcohol Concern's Blue Light project which assists workers to identify symptoms that indicate alcohol related health harm is emerging would be a real asset in tackling health problems
5. **Talking to problem drinkers about what will engage them in health services:** problem drinkers are interested in their health, they need to be consulted on how best to tap into that interest.

In addition, the report recommends:

- Physical effects training for non-alcohol specialist services that encounter problem drinkers e.g. homelessness services and probation/community rehabilitation companies. This would be an opportunity to roll out the 12 questions tool.
- Providing more information about the accuracy of liver function tests (LFTs), particularly to families. The limitations of LFTs in diagnosis are widely misunderstood. Blood tests do not identify the degree of fibrosis and can return negative results in patients with advanced fibrosis but no cirrhosis yet, which can result in an unwarranted sense of security, demotivate the drinker and impede the efforts that families have made to encourage someone to engage with health services.
- The report recommends this as a strategy offering both a significant return on investment and health gain for individuals.

Part 1 – Setting the scene

1.1 Introduction

In 2015, the Recovery Partnership published its *Review of Alcohol Treatment Services*¹: a comprehensive review of the current state of alcohol services in England. It drew on a national survey, interviews and workshops.

It highlighted a range of gaps and problems within alcohol services; but a widely expressed concern was that:

- *The physical health of alcohol service users is worsening.*²

Problem drinkers, it was felt, were entering services later and, therefore, were less well when they sought help. One respondent put it succinctly, if ungrammatically: alcohol services are seeing “*more iller*” clients.³

In other words: opportunities are being missed to reduce alcohol related health harm. This chimed with national concerns about the rising rate of alcohol related liver disease and other health harms. Therefore, the Recovery Partnership launched further research to:

- Identify ways of reducing the cost burden on health services by improving the health of people experiencing or at risk of alcohol related harm.

Alcohol related harm can be tackled through a wide range of approaches including: social marketing, pricing, licensing and treatment. However, this report has a limited focus. It simply explores whether opportunities to identify and address alcohol related health harms are being missed:

- By those working with problem drinkers, particularly specialist alcohol services
- By services supporting the families and informal carers of problem drinkers.

It identifies five simple, cost effective steps that can be taken to reduce the damage to individuals and the impact on health services.

1.2 The context – the need to tackle the physical effects of alcohol

Alcohol related illness and disease cost the NHS £3.5 billion per annum and the burden is increasing every year.⁴

The extensive data on alcohol-related health harm has already been set out in a number of documents.^{5 6 7} The government’s *Statistics on Alcohol, England, 2016* reported that:

In 2014/15, 1.1 million estimated hospital admissions had an alcohol-related disease, injury or condition as the primary or secondary reason for admission: 3% more than in 2013/14.

In the same year, an estimated 333,000 admissions had an alcohol-related disease, injury or condition as the primary diagnosis or there was an alcohol-related external cause. This is similar to 2013/14 and 32% higher than 2004/05.

In 2014, 6,831 deaths were related to the consumption of alcohol. This is an increase of 4% on 2013 and an increase of 13% on 2004.

Alcoholic liver disease is a particular concern. In 2014/15 it accounted for nearly two-thirds (63%) of all alcohol-related deaths.⁸ Public Health England has written:

“Liver disease is the third most common cause of premature mortality in the UK. Unlike all other major causes of mortality in the UK, liver disease mortality rates have shown a continued rise over the past half century. The liver disease mortality rate in the UK has increased by more than 400% since 1970 in contrast to a decline in mortality rate in all other chronic diseases over the same period. Comparative data from across Europe shows that this rise has not been seen in other European countries, highlighting the need to take action in the UK.”⁹

The *Local Alcohol Profiles for England* (May 2016) report that:

- Cancer incidence related to alcohol has seen a gradual upward trend for males and females over the past decade.¹⁰

This report starts with the assumption that the impact of alcohol related harm is well-proven and needs to be tackled.

Tackling alcohol related harm will also address a number of government indicators such as the NHS Outcomes framework indicators, in particular those about: *reducing premature mortality from the major causes of death* i.e.

- Under 75 mortality rate from liver disease (PHOF 4.6)
- Under 75 mortality rate from cancer (PHOF 4.5)
- One and five-year survival from all cancers;
- Under 75 mortality rate from cardiovascular disease (PHOF 4.4).

1.3 Methodology

The project has undertaken:

- An online survey of the views of staff in alcohol and generic services
- Workshops with the staff of alcohol services
- Re-analysis of earlier Recovery Partnership research
- Desk-based research.

The project also drew on:

- The Adfam/Alcohol Concern *Blue Light* Family project - this has considered the potential role that family members can play in identifying the onset of alcohol-related health problems.
- A pilot in the London Borough of Merton (with the support of the Safe Sensible London Partnership) of the *Blue Light* project's 12 questions tool which aims to support frontline workers to identify alcohol related health problems.
- Martyn Penfold's *Review of Pathways for the Prevention and Treatment of Alcohol Related Liver disease in London*.
- A review of the Nottinghamshire Alcohol Long Term Conditions Team which explored service user views of outreach and included a question about physical effects.

Conclusions are drawn from the work as appropriate, but it's worth bearing in mind that the sample sizes for some of the strands are small and not necessarily indicative of the country as a whole.

1.4 Acknowledgements

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Part 2 - Missed opportunities

This report is not the first use the phrase “missed opportunities” in regards to tackling alcohol-related health harm. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report on liver deaths, which was also critical of missed opportunities to identify liver disease before the terminal admission. At points this report echoes NCEPOD’s criticisms. It is to be hoped that this will be the last report to use the term.¹¹

The following sections set out six pieces of research that point to missed opportunities to tackle alcohol related physical harm:

- An online survey of worker views
- Interviews with service users in Nottinghamshire
- A pilot of Alcohol Concern’s 12 questions tool
- A consultation with carers and families of problem drinkers and those who work with them
- Workshops in specialist alcohol services
- Evidence from *A Review of Pathways for the Prevention and Treatment of Alcohol Related Liver disease in London*

At the end of each section we highlight the missed opportunities. Part 3 draws all this evidence together.

2.1 The online survey

An online survey was sent to a database of both alcohol specialist and non-specialist workers. This asked about the response from services and practitioners to the physical effects of alcohol. This survey suffered because of the change in project funding and it was never marketed as intended and many of the issues it addressed were not followed up. Nonetheless, it secured 67 responses, including 33 from non-clinical drug and alcohol specialists.

Two points emerged from the survey which are relevant to this report:

- 57% (19 out of 33 non-clinical drug and alcohol specialist respondents) had taken part in less than one day of training on the physical effects of alcohol. Comments included:
 - ❖ *“I have learned all I know via my own research and client interaction.”*
 - ❖ *“Most of my training took place many years ago.”*
 - ❖ *“This would have been a number of years ago.”*
- Every respondent believed that the stigmatisation of problem drinkers prevented them seeking help for physical health problems. Two thirds saw this as a significant or very significant problem. Comments included:
 - ❖ *“Alcohol abuse can prevent clients from asking for help as there is often significant shame and guilt associated with the abuse/inability to stop/subsequent*

physical ailments. There is often a need for advocacy with GPs to push through the barriers of stigma.”

- ❖ *“Clients often state that professionals see them as “just a drinker”, they feel they don't get appropriate treatment and drink is used as a reason not to treat them.”*
- ❖ *“Some state that they are poorly treated in hospital settings - judged and not taken seriously.”*
- ❖ *“Clients are cautious and reluctant to attend appointments because of the stigma attached to their drinking.”*
- ❖ *“I know that many hospital staff effectively write people off once they see 'alcoholic' written in a patient's notes.”*

This evidence highlights two missed opportunities:

- **Given the significance of physical health problems for problem drinkers the level of training in specialist alcohol services should be markedly improved.**
- **Stigmatisation and negative attitudes from professionals are making it harder for problem drinkers to seek medical help, thereby, increasing the future burden on health services.**

2.2 The service user view – Lessons from the Nottinghamshire Long Term Conditions Team

For the last three years the Nottinghamshire Healthcare Trust has run an Alcohol Long Term Conditions (LTC) team. This service is staffed by nurses and operates an outreach focused approach to some of the most chronic, high impact, problem drinkers. Although not unique, this outreach model is only being used in a handful of areas across the country.

The service was positively evaluated by Alcohol Concern in 2015 and flagged as a model of national good practice in its use of assertive outreach.¹² In 2016, a second review was undertaken by Alcohol Concern with the aim of:

- Understanding what service users felt were the most valuable aspects of the outreach approach.¹³

The research used a semi-structured interview format which avoided asking about specific features of the team in order not to skew the clients' comments.

The service users particularly valued the staff's knowledge about the physical effects of alcohol.

- *“The first thing is to look at physical condition and only then is the drinking discussed.”¹⁴*
- *“They know about the consequences.”¹⁵*
- *“They tell you what you are doing to your body. They do that technical stuff and how to deal with it.”¹⁶*
- *“They look at your physical health at the same time which felt like a double service. I was worried about my health.”¹⁷*
- *“The LTC team look after you both physically and psychologically. In most services it is separated.”¹⁸*
- *“They put the medical side in lay person's terms. They don't try to impress you.”¹⁹*

- *“Their knowledge is really detailed. Other workers blag it. If they don’t know they find out for you.”²⁰*

This aspect had not been considered by the researchers and was commented on unprompted, underlining its importance. It also challenges the stereotype perhaps held by some that drinkers do not care about their health.

A second, unprompted, theme was the negative response – the stigmatisation – that drinkers may receive from professionals in the healthcare system. Comments from the interviewees included:

- *“People do feel judged in hospitals and elsewhere. Some of the nurses on wards make you feel you have brought this on yourself and are unsympathetic.”²¹*
- *“You do find doctors and staff who are really unpleasant: one doctor made me feel it was self-inflicted and I didn’t want to bother.”²²*
- *“I have experienced negative stuff from A&E – from a nurse who was a bit abrupt, which upset me a bit. It didn’t seem very caring: “you are costing us millions”. I was in a bad place at the time and I didn’t want to know.”²³*
- *“I didn’t experience any problems with the doctors and the dietitian.”²⁴*
- *“People who go to A&E and other services are not treated well.”²⁵*
- *“Doctors, even now, are judgemental. Even the consultant at the hospital made me feel “that big”. The ambulance driver treated me like something you wouldn’t put your foot in. I was being talked to like a piece of shit.”²⁶*
- *“When you first go into the hospital the staff don’t want to know you. You are a hindrance.”²⁷*

A client in another area, met by chance during the research, related that, while in a hospital bed, a nurse had walked up to him and told him that he did not deserve to be in the hospital and his place should go to someone else.²⁸

Stigma has been raised as a problem in other research:

- Van Boekel et al. (2013) assessed health professionals’ attitudes towards patients with substance misuse disorders including alcohol. Health professionals generally had negative attitudes towards patients with substance misuse disorders. NICE clinical guidance [CG115]²⁹ has supported this finding and recommended improved education and training.
- The NCEPOD review into alcohol related liver deaths highlighted concerns about the current response to alcohol related liver disease in secondary care. It suggests that the clinical response can be influenced by moral judgements about a patient group who, on face value are ‘unwilling’ to do the one thing that will improve their chance of recovering from a disease.^{30 31}

NCEPOD:

“We also know that this is a group of people who are difficult to help. But they are still entitled to be treated on their clinical merits and given the care that would bring benefit... I fear that there is more than a hint of dismissive attitudes in many of these cases according to the advisors. The illness may be self-inflicted, like so many of the lifestyle diseases that bring patients to their doctors in modern society, and the prospects of a cure for many of

*these people may not have been propitious for some years. But the present concern about the quality of care delivered in our hospitals is as valid for them as it is for any other group of patients: no decent healthcare system should write people off or deem them less worthy of the best care available to them.*³²

This evidence reinforces the point already made in the survey about:

- **The negative impact of stigmatisation.**

However, it also highlights another missed opportunity:

- **Problem drinkers are interested in their health and should be actively engaged in discussions about how best to deliver health information.**

2.3 The 12 questions tool

The *12 questions tool* is part of Alcohol Concern's *Blue Light* manual.³³ It sets out 12 simple questions that staff such as non-medical alcohol workers, probation officers or housing workers can ask drinkers which will highlight emerging health problems. It is not a general, population-wide, screening tool like AUDIT³⁴; the target is people who are showing signs of alcohol misuse. The tool is included as appendix 1.

The tool has been greeted with enthusiasm by health personnel as a contribution to the earlier identification of alcohol-related health problems. It has been praised by both NHS England and Public Health England. It has also been praised at the local level. Dr Steve Ryder, a leading liver expert at Queens Medical Centre in Nottingham asked: *why has no-one has thought of this before?* Dr Ryder has put his name to the tool to validate its clinical content.

- The tool still needs to be subject to a peer-reviewed academic study; however, Alcohol Concern and the Safe Sociable London Partnership have undertaken a small trial of this tool in Merton with the aim of justifying further review. The trial used only the first 10 questions of the tool. For technical reasons, it excluded two questions (regarding birth control and blood pressure check) which need to be redesigned to facilitate consistent scoring and recording. "The tool was used by 11 workers in three settings: an alcohol service, by non-medics in A&E and in a homelessness service."
- "The tool was completed with a total of 65 individuals."
- "37 (57%) had responded positively to one or more of the 10 questions."
- "19 (29%) had seen a GP or A&E doctor as a result of the information."
- "Positive responses ranged across the 10 questions and were not limited to one or two of the questions."

Comments from the workers endorsed the use of the tool:

- *"It has helped in raising awareness to the harmful effects of alcohol that clients are not aware of."*
- *"I found the tool useful in the assessment stage of engagement to suggest to clients that they should visit their GP. It helps them to start to take responsibility for their own self-care whilst they enter into treatment."*
- *"I have managed to ask nine people so far. Five people were identified with*

- symptoms and I advised them to go to their GP or A&E which they have all done.”*
- *“They have been helpful in terms of getting them to reflect on possible effects of alcohol on the body, and some of them did recognise some signs on themselves.”*

The tool is also being used in other areas e.g. homelessness services in Cardiff. These have not been evaluated in the same way but the feedback is again positive.

The 12 questions framework requires a peer reviewed academic study. However, these results alone are very encouraging and the responses from the workers indicate this tool is increasing the identification of physical health problems.

The key to this tool is its focus on symptoms rather than disease. Frontline workers will not encounter “pancreatitis” or “neuropathy”: they will encounter the symptoms. Telling a worker that alcohol misuse risks cirrhosis, pancreatitis or neuropathy is only of partial help. Both workers and clients need to know the symptoms that will be experienced.

The approach could be used by both alcohol specialist and non-specialist services. Health services remain responsible for identifying and tackling health problems but this task will be facilitated if services including the prison, custody suite, probation and housing attempt to play their part in early identification, referral and the provision of information.

This evidence highlights a missed opportunity to:

- **Give both alcohol specialist and non-alcohol specialists simple tools which help them identify the physical effects of alcohol.**

It also underlines the need to:

- **Ensure that training on alcohol related health problems for non-medical staff concentrates on symptoms that will be seen not just the conditions that alcohol causes.**

2.4 The family dimension

The *Blue Light* family project is an initiative that aims to identify whether, and how, family members can be encouraged to be a resource in tackling change resistant drinkers. In the initial phase Alcohol Concern and Adfam researchers ran workshops with carers, and those working with carers, in 19 local authorities ranging from North East to South West England.

In each workshop two questions were asked which were relevant to this research:

- Would it be useful to family members to be more aware of the signs and symptoms of key alcohol related health problems?
- Should family members be provided with a tool similar to the 12 questions tool to support this?

In every workshop:

- Workers were clear that it would be useful for family members to know more about impacts on physical health
- Family members were keen to be better educated about the signs and symptoms of alcohol’s physical effects.

Families and carers offer significant, untapped potential for tackling alcohol related health problems. The consensus was that an adapted version of the 12 questions tool would be helpful. This could be easily adapted to make a '12 things to look out for' resource.

A second issue emerged in the family workshops and also in the other research for this project: concerns about the impact of liver function test results.

A liver function test is a blood test looking for a range of biological markers. Liver function tests may be suggested by doctors if someone has a pattern of heavy drinking and/or symptoms of liver damage. Blood tests are a useful tool in diagnosing liver damage but they are not as accurate as many other medical tests. They may indicate that someone is clear despite significant levels of drinking and actual harm. NICE Guideline 50 on the assessment of cirrhosis makes this point very clearly. One of its recommendations is not using "routine laboratory liver blood tests to rule out cirrhosis".³⁵

Clear results can be de-motivating for drinkers and confusing for family members. They may persuade the drinker that nothing is wrong and undermine the efforts that the family has made in encouraging them to talk to a doctor.

It is important to contextualise the results of these tests. A clear test does not rule out the possibility that:

- This test did not find any damage – there may still be unidentified damage
- Damage may still develop
- The drinker may have damage, or be at risk of damage, to other organs
- The drinker may be harming non-physical aspects of their life such as their relationships.

Without this information the liver function test results may be counterproductive.

This data has highlighted a further missed opportunity:

- **Family members are keen to be better educated about the signs and symptoms of alcohol's physical effects and offer an untapped potential for support.**

In addition:

- **More information and awareness is needed about the accuracy of liver function tests.**

2.5 Reviewing knowledge in specialist alcohol services

The Recovery Partnership *Review of Alcohol Treatment Services* raised questions about professional training and whether the pressure to reduce costs has reduced knowledge about physical ill-health in alcohol services.³⁶ Typical comments included:

- *"The staff are inadequately trained to deal with the physical disease, mental health and complexity of service users."*
- *"...less staff, with less skills and less resources."*
- *"We are seeing a move away from medical skills."*
- *"There are too many unqualified staff."*
- *"It is harder to recruit nurses because we have a non-statutory provider."³⁷*

No-one argued that the staff of alcohol services should all be medically qualified, whether that be as nurses or doctors. However, the comments suggested that the swing away from employing nurses and doctors has gone too far. Moreover, the current staffing had received too little training on physical effects to compensate for this imbalance.

As a result, the researchers ran workshops with three groups of workers in local substance misuse services to identify potential gaps in knowledge.

The workshops followed an agreed pattern:

- A group of workers was gathered for a two-hour training session.
- Participants were asked to complete a pre-course questionnaire about their knowledge, confidence and practice regarding the physical effects of alcohol.
- The questionnaires were collected.
- The two-hour training session was run.
- A post course questionnaire was distributed which asked participants to reflect on their knowledge, confidence and future practice regarding the physical effects of alcohol.

The collected data provided an insight into the current knowledge and practice around physical effects. The identity of the services will not be published in case any erroneous judgement is made as a result.

The project surveyed and trained 50 workers in three community alcohol services. It was interesting to note that:

- Only 5 (10%) had a qualification as either a nurse or a doctor.

This figure may be misleading because medical personnel could have opted out of the process. Nonetheless, it highlights that a significant number of people working with problem drinkers on a daily basis do not have training as a doctor or nurse.

The initial questionnaire asked:

On a scale of 1-10 how would you rate your knowledge about the physical effects of alcohol?

- The average response was 6.7 with a range of 3 to 10.

The initial questionnaire also asked:

Have you had formal training in the physical effects of alcohol?

- 62% of the respondents had had less than one days training.

After completing this questionnaire, respondents received a two-hour training course on the physical effects of alcohol. The course had been designed by a medically qualified individual but was delivered by a non-medical trainer. (The ability of non-medical personnel to deliver training will be important if training focused on developing physical health harms knowledge is to be rolled out widely.)

Participants were then asked to complete a second survey. The first question repeated a previous question:

On a scale of 1-10 how would you rate your knowledge about the physical effects of alcohol?

- The average response was now 8.3 with a range of 5 to 10. A rise of 1.6 points or 19%.

Further questions asked:

Has the course increased your confidence in discussing the physical effects of alcohol? Will it change your practice?

- 90% of participants said that the course had increased their confidence with only 4% saying no (6% did not reply).
- 83% said it would change their practice with clients (8.5% said it would not change practice).

Participants were asked about the appropriateness of a two hour course:

- 87% thought it was about the right length (only 4% thought it was too long).

This very simple exercise has shown:

- The number of alcohol workers who do not have a qualification as a nurse or doctor
- The ongoing need for training on the physical effects of alcohol within mainstream alcohol services
- The degree to which very simple training inputs can influence confidence, knowledge and practice

This suggests another missed opportunity:

- **The benefits of a large-scale but simple training programme for alcohol service staff nationally.**

2.6 A Review of Pathways for the Prevention and Treatment of Alcohol Related Liver disease in London

Penfold (2016) is a review of current responses by a number of key services to alcohol related liver disease (ARLD) in London.³⁸ This is a thorough review and makes a number of important recommendations. These are much broader than the focus of this report and deserve separate consideration. However, the report makes three points that are relevant here:

- *“Many of those diagnosed with ARLD live with or have contact with family members who have experienced the stress of living with addiction.”³⁹*
- *“Greater effort should be made to target liver health programmes at those groups that may be at a higher risk of alcohol related liver disease, including homeless adults, street drinkers and offenders.”⁴⁰*
- *“...efforts need to be made to ensure that staff in addictions services have a good understanding of liver disease and other alcohol related disease, including Wernicke Korsakoff...”⁴¹*
- **These very clearly support earlier missed opportunities around involving family members, engaging a range of services in targeting alcohol related health conditions and the need for further training for alcohol workers.**

Part 3 – Discussion & recommendations

3.1 Missed opportunities

The starting point for this report is the huge impact that alcohol related health harm has on problem drinkers, their families, the NHS and other services. This report has not tried to assess this burden; it has simply taken it as proven. The question asked is: what can we do about it?

This research has identified **five missed opportunities to improve the health of problem drinkers:**

1. **Improving the physical effects training of non-medical alcohol service staff:** around 60% of non-medical specialist alcohol workers surveyed as part of this project have had less than one day's training on the physical effects of alcohol
2. **Challenging the stigmatisation of problem drinkers in generic healthcare and other services:** problem drinkers are identifying intense prejudice when entering healthcare (and other services)
3. **Educating families to identify health problems:** families and informal carers are an untapped resource in recognising health symptoms at the earliest opportunity and supporting engagement with health services
4. **Disseminating a symptoms based identification tool:** which assists workers to identify symptoms that are of concern is emerging as a real asset in tackling health problems
5. **Consulting problem drinkers on what will engage them in health services:** problem drinkers are interested in their health, they need to be consulted on how best to tap into that interest

Data from the online survey, the workshops and from the research in Penfold 2016, suggests that the vast majority of specialist alcohol workers are:

- Not medically trained.
- Likely to have had less than one day's training on the physical effects of alcohol.

The workshops highlighted the potential benefit from brief training programmes on the physical effects. In conjunction with the use of a symptoms identification tool such as the 12 questions, clear scope exists for increasing the identification of alcohol related physical harm in alcohol services.

Many generic workers, for instance people working in homelessness and housing services and CRC /Probation services, are in a position to identify alcohol-related harm. The research into the 12 questions tool suggests that a simple and widely used tool could increase the rate of identification of health problems.

However, responses from the survey, and the client interviews, suggested that a second approach is needed with generic workers: efforts to challenge the stigmatised response that many drinkers have experienced in the health care system (as well as other settings). These attitudes are a significant barrier to engaging problem drinkers in health services.

Family members can play a role in identifying more specific health problems as they develop. They will be the first to see the symptoms of health harm: the clumsy hands due to peripheral neuropathy, the pains in the back or blood being coughed up or excreted.

The evidence from the *Blue Light* family project identified the fact that families are not only in a good position to identify harm but are also keen to do so. A version of the 12 question tool could help family members identify emerging problems. This could be provided to family members as a prompt.

The evidence from the Nottinghamshire service users highlighted the stigma and prejudice that drinkers can receive, but it also highlights that problem drinkers are concerned about their health. As a result, work should be undertaken to engage problem drinkers in a national conversation about how to best engage people in talking about their health.

One contributor to this research suggested that problem drinkers should be targeted with first aid courses. This could be presented as a means of helping other drinkers who collapse or complain about health problems, but would have the advantage of also educating the drinker.

Both families and problem drinkers would benefit from work on providing more information about liver testing. Clear results can easily be misinterpreted and demotivate both a drinker and impede the efforts that families have made to encourage someone to engage with health services.

3.2 Recommendations

In order to address these five missed opportunities, this report makes a brief series of recommendations. None of these interventions are particularly expensive: particularly when set against the costs of alcohol related health harm.

➤ **Improve alcohol worker training**

- Work should be undertaken to agree what non-medical alcohol specialists should know about alcohol-related health harm and turn this into a curriculum for a brief training course. This should focus, in particular, on helping people identify symptoms that can be observed and asked about.
- The training course should include a symptom identification approach so that training can become on the ground action with clients.
- The training programme should be rolled out around the country to non-medical alcohol specialists and evaluated.

➤ ***Roll out the 12 questions tool***

- The 12 questions tool should be rolled out and evaluated in non-specialist services which are likely to see individuals with a greater risk of alcohol related harm.

➤ ***Challenge stigma in healthcare services***

- A national programme of work is needed to identify and challenge the stigma that exists in healthcare services towards problem drinkers.

➤ ***Engage family members***

- Leaflets, other information and training should be developed to help the family members of problem drinkers to identify alcohol related health harm in the people they care for.
- More information needs to be available to families about the accuracy and meaning of Liver Function Test results.

➤ ***Consult problem drinkers***

- Work should be undertaken nationally to listen to service users' views on what would assist engagement with health interventions.

➤ **Pursuing these missed opportunities represents an 'invest to save' strategy with the potential for significant returns.**

12 Questions

for the Generic Worker to ask about alcohol related physical ill health

Workers' questions to Service Users

Below is a list of 12 questions that will be useful to ask when speaking to a service user about their physical health. We are not expecting you to be a medic but here are some simple questions to ask. Please refer to the explanatory notes and encourage them to see their GP with any health issues. Some people have suggested that this is a task for doctors or nurses. However, if we only wait until they see a clinician we will be missing real opportunities to prevent health problems.

It is suggested that an open ended question is used at the beginning of the conversation such as: Alcohol increases the risk of over 60 different diseases. Have you had any recent health problems? Then get permission to ask the further 12 questions: Can I run through some other health related questions?

1. Do you ever experience a painful feeling of heaviness or tightness, usually in the centre of your chest, which may spread to your arms, neck, jaw, back or stomach?
2. Have you coughed up blood or noticed blood in your vomit?
3. Have you ever noticed or has someone else commented that the whites of your eyes or your skin have turned yellow?
4. Have you passed any blood from your back passage?
5. Do you have a sensation of numbness or pins and needles in your feet or hands?
6. Have you ever experienced fits (seizures)? Have you a history of head injuries (Including non alcohol related and as a child)?
7. Have you lost or gained weight unexpectedly recently?
8. Have you noticed that you bruise more easily than normal?
9. Do you experience or have you experienced a severe, dull pain around the top of your stomach that develops suddenly?
10. Have you or a relative/carer expressed concerns about your memory?
11. Are you practising safe sex? (Applies to males and females) Are you using contraception? (Applies to males and females) Are you thinking about or considering becoming pregnant? (Females only)
12. Have you recently had your blood pressure checked or had a blood test?

The 12 questions were developed by Mike Ward & Mark Holmes with clinical input from Dr Stephen Ryder Consultant Hepatologist at Nottingham University Hospitals NHS Trust.

12 Questions for the generic worker to ask about alcohol related physical ill health

Explanatory notes

If there are health concerns you need to encourage them to see their primary care team and in certain circumstances to seek urgent medical attention:

1. Do you ever experience a painful feeling of heaviness or tightness, usually in the centre of the chest, which may spread to the arms, neck, jaw, back or stomach?

This question explores if there have been any symptoms of a heart attack. If they answer yes it would be worth asking when they last experienced this and how long did the pain last for. If the symptoms are active this will lead to an emergency call. Previous symptoms should be discussed with a health care practitioner.

 **Seek urgent medical attention**

2. Have you coughed or noticed blood in your vomit?

A relatively common gastroenterological reason for alcohol related hospital admissions is called a Mallory-Weiss tear which can occur following prolonged and forceful vomiting, coughing or convulsions. Typically the mucous membrane at the junction of the oesophagus and the stomach develops lacerations which bleed, evident by bright red blood in vomit, or bloody stools. Large amounts of blood maybe due to ulceration or oesophageal varices. The amount and colour of blood (coffee grounds to bright red) will be helpful information for a medical practitioner.

 **Seek urgent medical attention**

3. Have you ever noticed or has someone else commented that the whites of your eyes have turned yellow?

The aim is to identify potential alcoholic liver disease. Even in advanced liver disease there may be no symptoms, so these questions are markers to pick up potential or actual problems. The speed of noticing the colour change is important as this could be potentially life threatening alcoholic hepatitis.

 **Seek urgent medical attention**

4. Have you passed any blood from your back passage?

If the answer is yes we suggest asking about the colour of the blood. A bleed in the area from the mouth to the stomach can be digested by the stomach. This tends to be black with a consistency of tar. Bright red blood that appears on toilet paper after wiping maybe a symptom of haemorrhoids (piles). Lower bleeds in the bowel will appear 'blood red' or light red. This will also require medical advice as it can be a symptom of other physical disease. The loss of large volumes of blood can indicate complications of liver disease and prompt action will be required.

 **Seek urgent medical attention**

5. Do you have a sensation of numbness or pins and needles in your feet or hands?

This question aims to detect Peripheral Neuropathy. This is a problem with the nerves that carry information to and from the brain and spinal cord. This produces pain, loss of sensation, and inability to control muscles. The pain is sometimes a shooting pain in the arms or legs. This is a largely treatable condition affecting the nerve endings which can be managed with a combination of pain relief, vitamins and abstinence from alcohol. However, it could cause clumsiness and accidents e.g. cigarette burns.

6. Have you a history of head injuries (Including non alcohol related and as a child)?

A history of head injuries can be a precursor to alcohol related brain injury. There is also research suggesting that head injuries in childhood may affect personality traits leading to impulsive behaviours. If the service user has a previous history of alcohol withdrawal seizures, there is a 10-fold increase in risk of seizure in withdrawal. Alcohol related seizures are not only caused by withdrawal. For example alcohol beverage consumption can change the chemistry of minerals in the blood stream or trauma to the head can lead to seizure.

7. Have you lost or gained weight unexpectedly recently?

Another symptom of liver disease is ascites. This is fluid that is retained and may be noticeable around the liver and abdomen and ankles. However often smaller amounts are not noticed. Weight gain may be a sign of this. Weight loss may also be a sign of muscle degeneration or symptom of an underlying medical condition.

8. Have you noticed that you bruise more easily than normal?

Another symptom of liver disease is bruising caused by the person not making enough clotting factors in the blood. The bruises may appear without injury or be worse than expected when injury has occurred.

9. Do you experience or have you experienced a severe, dull pain around the top of your stomach that develops suddenly?

This question aims to detect acute pancreatitis. "Often people experience pain in a different place than the area affected – this is often called 'referred' pain." Service users sometimes confuse this as stomach ache or back pain.

10. Have you or a relative/carer expressed concerns about your memory?

There is growing evidence about the effects of alcohol on the brain, in particular the frontal lobes. This can cause not only memory problems but personality changes and poor energy levels. Consideration should be given to how this may impact on accessing treatment services. These questions are also a good prompt to remind service users and carers of the importance of a balanced diet and in particular the need to take vitamin B. If vitamin supplementation is not prescribed then this should be considered/arranged.

11. Are you practising safe sex? (Applies to males and females) Are you using contraception? (Applies to males and females) Are you thinking about or considering becoming pregnant? (Females only)

All age groups and both genders need to have information about safe sex. NICE advice on drinking in pregnancy is that women should abstain from alcohol completely during the first three months of pregnancy because of the risks of miscarriage; and to drink no more than one or two units of alcohol once or twice a week for the rest of the pregnancy.

12. When was the last time you had your blood pressure checked or had a blood test?

These questions open up discussion with the service user about recent contact they have had with health professionals and what concerns have been raised. If the service user has not had bloods taken recently (last 3 months) then steps should be taken to approach a health care practitioner to see if further tests are required. There is a clear link between high blood pressure (hypertension) and alcohol.

The 12 questions were developed by Mike Ward & Mark Holmes with clinical input from Dr Stephen Ryder Consultant Hepatologist at Nottingham University Hospitals NHS Trust.

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- ¹³ As yet unpublished but to be available from Alcohol Concern later in 2016
- ¹⁴ Interviewee 2
- ¹⁵ Interviewee 3
- ¹⁶ Interviewee 5
- ¹⁷ Interviewee 2
- ¹⁸ Group interview
- ¹⁹ Ibid
- ²⁰ Ibid
- ²¹ Interviewee 4
- ²² Interviewee 6
- ²³ Interviewee 5
- ²⁴ Interviewee 8
- ²⁵ Interviewee 2
- ²⁶ Group interview
- ²⁷ Ibid
- ²⁸ Anonymous client comment
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