Eastern Regional
Health Authority

Údarás Réigiúnda
Sláinte an Oirthir

Alcohol Services - Agenda for Action

Developing an Integrated and Enhanced Response

October 2003

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Foreword

The increase in alcohol consumption in Ireland is a matter of concern. This is especially so for the health services which frequently have to deal with the results of alcohol-related harm. The impact of the growing consumption affects the lives of so many people and not just those individuals with an alcohol problem. In particular, the quality of life of many families is seriously undermined.

The health services rightly provide a response to alcohol misuse in society and this report sets out a framework for improvements in these services. But this is not a matter solely for the health services. What is required is concerted action across different sectors. **In short it is everyone's responsibility.**

The Eastern Regional Health Authority fully supports measures to regulate availability and to provide for effective enforcement of relevant legislation. It welcomes and fully supports the measures recently introduced under the Intoxicating Liquor Act 2003 which addresses public order and health concerns arising from excessive alcohol consumption.

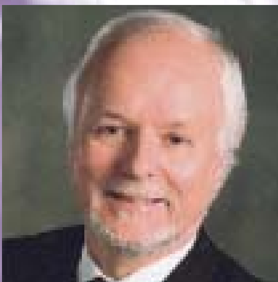
It is important to stress that while the Authority is opposed to excessive consumption it has no difficulty with the sensible consumption of alcohol. In order to achieve the moderation required, attitudes need to change.

It gives me great pleasure to launch this report in conjunction with the Conference, *Action on Alcohol*, as an important contribution by the Authority to changing the culture on alcohol consumption.

Alderman Joe Doyle
Chairman, ERHA

Introduction

This report provides an overview of the harmful effects of the increased alcohol consumption within the eastern region and the steps we need to take to address and respond to this important issue. Alcohol consumption is endemic in Irish society and has a strong association with many of our rituals and customs. Unfortunately it is also inextricably linked to many of our health and social problems also. Prevention and management strategies in this area are inter-linked and it is important to recognise that the health response is but one of a number of different responses required to achieve real change. We have set out a programme of actions underpinned by research evidence with a transparent implementation process. The urgent need to expand, grow and support our present alcohol services is acknowledged along with the importance of ensuring that this is done in a phased and sustainable manner. We endorse and fully support the recommendations in the Strategic Task Force on Alcohol and are firmly committed to working in a conjoint and inter-sectoral manner. The pervasiveness of alcohol as a problem across society means that even modest change towards more sensible drinking patterns will require support to be mobilised across many different sectors. The ERHA, as the statutory body responsible for supporting the health of the 1.4 million people living in the region, has a particular interest in promoting the inter sectoral approach required to tackle this issue. We are committed to the implementation of this plan given the necessary resources and wish to acknowledge and thank the Alcohol Working Group and the Board of the ERHA for their input to this report.



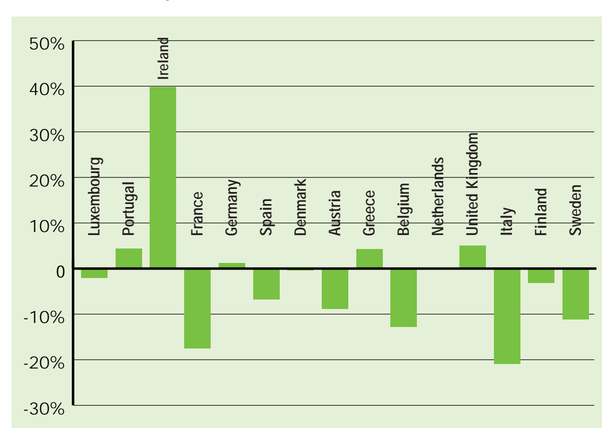
Michael Lyons,
Regional Chief Executive, ERHA

Context

Some of the well-established and evidenced facts and trends concerning alcohol consumption and the role of alcohol in Irish society bear repetition.

- In recent years there has been an inexorable rise in per capita consumption of alcohol. Consumption per capita increased by 41%, from 7.6 litres of pure alcohol (1) in 1989 to 11.1 litres in 2000 (Fig. 1). In the process, Ireland has outstripped many other EU countries. The EU average per capita consumption was 9.1 litres of pure alcohol in 2000.
- Within the EU, Ireland ranks second to Luxembourg in per capita consumption of alcohol. The increased level of consumption in Ireland is contrary to almost all EU countries, where alcohol consumption has either remained stable or has shown a decrease (see Appendix 1)
- Healthcare costs of alcohol related problems was estimated to be €279 million nationally in 1999.
- Problematic alcohol use pervades all age groups and all social classes
- The relative expense involved in choosing non-alcoholic drinks over alcohol has been continuously highlighted but remains an issue to be addressed in the promotion of moderation.
- The SLAN survey 2002 indicated that 30% of males (27% in 1998) and 22% of females (21% in 1998) consumed more than the recommended weekly limits of sensible alcohol consumption.
- Recent research indicates that the pattern of drinking too much on a single occasion is a stronger predictor of alcohol related problems such as impaired driving, aggressive behaviour, assaults, suicide and criminal violence, than overall consumption
- Children and adolescents are particularly vulnerable to alcohol related harm, given their physical and emotional immaturity.
- Alcohol consumption is endemic in Irish society and is inextricably linked with many of our rituals and customs.
- The quality of life of other family members can be seriously compromised where one member has an alcohol problem. Indeed not only the quality of life but the essentials of family life may be compromised – e.g. money for food, rent, children's clothes or shoes
- While the National Roads Authority was unable to provide precise information in relation to alcohol and road traffic accidents, it estimates that alcohol is a significant factor in 40% of fatal accidents and 35% of serious injury accidents, and that it is probably a significant factor in 50% of fatal pedestrian accidents.

Fig 1 Percentage Change in per capita alcohol consumption in EU Countries 1989-1999



Source: Strategic Task Force on Alcohol: Interim Report (2002)

Increasing concern with alcohol misuse and its impact on individuals, families and society is reflected in recent policy documents and initiatives. These include:

- *The National Task Force on Alcohol, Interim Report* (2002) made a number of recommendations mainly focused on national policy and legislative responses.
- The *Health Strategy, Quality and Fairness - A Health System for You* (2001) outlines a number of actions relating to alcohol which include measures to promote sensible alcohol consumption and those relating to alcohol advertising. Other actions in this strategy also include reference to alcohol and include domestic violence, mental health, older persons and suicide prevention.
- The *EU Alcohol Action Plan and Charter* highlights key policy goals for member states. It set a number of objectives for 2000-2005.
- The *Declaration on Young People & Alcohol* sets out specific recommendations and targets to respond to the harmful effects of alcohol on young people. The rationale is that protecting and promoting the health and well being of children and young people are central to the UN Convention on the Rights of the Child.

(1) Among different drinks such as wine, beer and spirits, a litre of pure alcohol is calculated according to the alcohol content. For example, approximately 8 litres of wine or 25 litres of beer is equivalent to 1 litre of pure alcohol.

- The *National Health Promotion Strategy 2000-2005* identifies schools and colleges and the youth sector as key settings for protection and promotion of health and well being of young people.

Principles

A number of principles are important in providing a framework for development of a response to alcohol misuse. These include:

Recognising that the health response is only one of a number of different responses required to bring about real change.

Building on interventions which have shown evidence of effectiveness

Tailoring interventions to the needs of specific client groups e.g. persons with disabilities, homeless persons.

Emphasising the importance of brief and frequent interventions as a means of helping to reduce the escalation of alcohol problems at an early stage.

Providing support services for family members of persons with alcohol problems.

Alcohol Problems and Models of Treatment

There are different views on the genesis of alcohol problems and behind each concept there is a corresponding treatment model (2)

The disease concept views persons who are alcohol dependent to be a homogenous group of people who in some way (genetically, physiologically) are predisposed to the 'disease' of alcoholism. This is considered to be a chronic, progressive condition with dominant features such as tolerance, dependence and loss of control over consumption. According to this concept, the use of alcohol by the general population is in the main irrelevant as it is not alcohol itself that is seen as the problem but the fact that some individuals are pre-disposed to becoming alcoholic. The 12 step treatment model, usually referred to as the Minnesota model (3) is a main treatment response on the disease spectrum. Abstinence from alcohol and other psychoactive drugs is the desired outcome as is becoming a sponsor or model to others.

The idea that alcoholism is a disease was the accepted concept up to the 1970's when epidemiological studies such as that by Ledermann were revisited (Ledermann, 1956) What is commonly called the Ledermann Curve essentially suggested that there was a connection between per capita consumption and the level of alcohol problems in a given population. Work by the World Health Organisation (1978,1980) highlighted this relationship and began a debate about alcohol related problems as distinct from alcoholism, endorsing a public health framework as opposed solely to a treatment framework. The move from a total acceptance of the disease model to that of a broader public health approach has enabled crucial developments in treatments for persons with alcohol problems. Thus, responses such as brief interventions, social skills training, community reinforcement approach and motivational interviewing are widely accepted and complement measures to regulate the availability and consumption of alcohol. It is also recognised that health services should be targeted within health and other settings and should work with other government bodies to promote protection and prevention.

Settings Approach

It is now widely acknowledged that an effective response to alcohol misuse must be multi-faceted and multi sectoral. The Authority recognises that no one response can be effective in dealing with such a complex problem and that, if some measure of success is to be achieved, the response must be multi-faceted, integrated, structured and resourced adequately. We believe and are committed to this way of working and indeed this was the basis of the recommendations made in *Towards Moderation, Use of Alcohol among People in the Eastern Region* (2001).

There are many opportunities to identify alcohol problems in health care settings such as primary care and hospitals that are not being realised to their full potential. Opportunities may also arise in workplace, education and leisure settings. Opportunities also arise in other health and non-health settings to identify and address alcohol problems in the workplace, education, sport and leisure settings as well as the areas concerned with justice, crime and road safety.

(2) This section draws almost exclusively on O'Sullivan, C., (2002) *Development of Community Alcohol Services in the Eastern Regional Health Authority*, MSc Thesis, Trinity College Dublin.

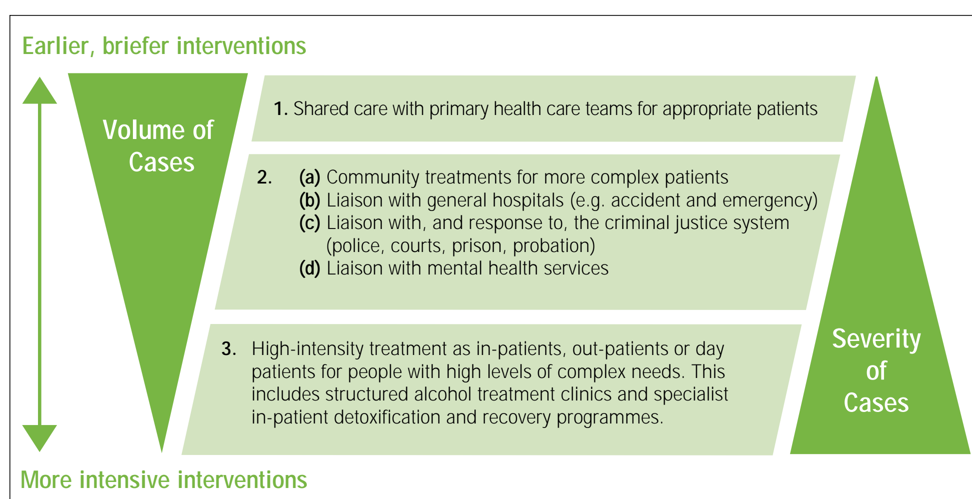
(3) The Minnesota model derives its name from a method of addiction treatment developed by Dan Anderson, a psychologist at Wallmar State Hospital, Minnesota in the 1950s and further developed by him at the Hazelden Foundation, Center City, Minnesota. The model is based on the 12 step philosophy of Alcoholics Anonymous (AA). It is characterised by a thorough and ongoing assessment of all aspects of the client and may include group and individual therapy, family education and support and other methods.

Primary Care:

Primary Care is an approach to care that includes a range of services designed to keep people well. These services range from promotion of health and screening for disease to assessment, diagnosis, treatments and rehabilitation as well as personal social services. They provide first level contact that are fully accessible by self – referral, are non stigmatising and have a strong emphasis on working with communities and individuals to improve their health and social well being. As a first port of call, primary care can potentially meet 90 – 96% of all health and personal social service needs. The Primary Care Strategy (2001) and the work taking place on its implementation provides an excellent opportunity to cross cut with the development of alcohol services. A range of individuals and organisations are involved in primary care services and they are delivered from a number of settings across the statutory, voluntary and community sector. The services are not only provided by GPs but also by public health nurses, practice nurses and community pharmacists. The settings include health centres, primary care centres, shelters and private premises.

In primary care, patients with alcohol problems consult approximately twice as often as the average patient, though not necessarily for help with alcohol problems per se. There is considerable evidence that earlier intervention can help to reduce escalation of alcohol problems while complex cases will require more intensive interventions (see Fig.2). However, despite this evidence, several studies indicate that some health care professionals have negative attitudes to patients who are alcohol dependent and tend to be pessimistic about treatment outcomes. Three main factors have been identified underpinning the lack of response from primary care workers; concerns about role adequacy (*can I deal with it?*), role legitimacy (*should I deal with it?*) and role support (*who's going to help me deal with it?*) (O'Sullivan, 2002).

Fig. 2 – Essential Facets of an Alcohol Service



Source: Adapted from Royal College of Psychiatrists London, Advice to commissioners and purchasers of modern substance misuse services, Council Report CR100, 2002, p[.8

Hospitals:

The detection of alcohol-related disorders in hospital settings is significantly under developed and under supported. Research carried out by Sheehan et al in the Mater Hospital has indicated that 30% of male admissions, 8% of female admissions and almost 25% of A&E attendances met diagnostic criteria for alcohol misuse or dependency.(4) The question must be raised as to why patients with alcohol-related problems are so seldom identified and referred? It is possible that doctors may underestimate the importance of alcohol as a co-morbid risk factor and fail to understand the benefits of early brief interventions. There may be uncertainty in the accurate quantification of alcohol consumption and a lack of awareness of the efficiency of existing screening tools and/or there may be a lack of local resources for the treatment of excessive alcohol consumption. Sheehan et al identify two key elements to the success of a strategy aimed at health promotion and secondary prevention of alcohol related harm in a general hospital setting. These are

- Awareness among doctors and other health professionals of the importance of alcohol consumption as a co-morbid risk factor
- The importance of systematically screening all patients for excessive alcohol consumption

(4) Hearne, R., Connolly, A., Sheehan., J.,(2002) *Alcohol Abuse: Prevalence and Detection in a General Hospital*, Journal of the Royal Society of Medicine. Vol. 95, pp.84-87.

Workplace settings:
The evidence of the significance of the workplace in helping prevent and treat alcohol problems has grown substantially. Many organisations now operate workplace alcohol policies designed to ensure that management and employees are sober during working hours, are aware of the number of days lost due to problematic alcohol use and are resourced and supported to identify and help employees with an alcohol problem.

The policy objectives of workplace interventions generally fall into five categories:
- Prevention of alcohol problems
- Prevention of alcohol interfering with work
- Commitment to ensuring the welfare of employees
- Provision of help for employees with alcohol problems
- A commitment to education, training and monitoring

Clearly with a combined staff force across the health and social services in the eastern region of over 37,000, priority for such a policy initiative will be important. Although workplace policies on drugs/alcohol, smoking, physical activity and nutrition were developed in the region in 2000 within the health promotion programme, only smoking and nutrition policies have been widely implemented. However, specific policies have been developed in relation to alcohol and the workplace in the Northern Area Health Board and an accompanying training programme was developed for managers to support this initiative

Apart from individual interventions, it is also important that the workplace provides a supportive environment. Examples of environmental supports include ensuring that celebrations, social activities and receptions are not centred on alcohol.

Targeting Responses
Alongside a settings approach, targeting services towards particular groups has also been shown to be effective in developing a comprehensive response. For example, there is a need to ensure that services are accessible to groups that tend to encounter difficulties or where interventions need to be tailored to improve effectiveness. These groups include homeless people, young people, people with disabilities, carers, travellers, people from ethnic minorities and those with mental health issues. It is equally important to develop responses that target both visible and less visible patterns of alcohol use and alcohol related harm and to highlight issues among certain groups which do not receive sufficient attention.

One such area of concern is associated with pregnancy. The risk of unplanned pregnancy is increased in the context of high alcohol consumption. Also requiring attention is the lack of knowledge of the consequences of excessive drinking in pregnancy. Foetal Alcohol Syndrome or more relevantly Foetal Alcohol Effects is an area of specific risk with serious consequences for children born to women drinking to excess during pregnancy. Interventions for this group, not only relating to alcohol misuse but also to tobacco consumption, will have important and beneficial effects.

While the problems of young people drinking are the subject of much concern and debate, it must be acknowledged at the outset that excessive alcohol consumption is a societal problem and young people's behaviour is reflective of wider norms. Problematic patterns of use tend to be more visible among young people. Notwithstanding this there is cause for concern at the impact of alcohol misuse on children and young people. Research suggests that drinking and intoxication are pervasive behaviours amongst young people and that such behaviours are perceived as the norm in the context of leisure activities. The Health Behaviours in School Aged Children Survey indicated that over half of young people begin experimenting with alcohol before the age of 12. In the younger age groups (under 15) more boys than girls are current drinkers, about one in five of the 12 – 14 year old boys are current drinkers. By the time they reach 15-16 age group, half of the girls and two thirds of the boys are current drinkers. Of particular concern is the level of binge drinking and drunkenness. The question must be posed as to where some young people access alcohol? The very young (under 15 years) either obtain alcohol at home, are given it by their parents or older siblings or by friends who buy alcohol for them. The older age group (post 15years) access alcohol mainly through pubs, clubs/discos and off licenses. Young people are knowledgeable about and influenced by

alcohol advertising that link alcohol to a variety of desirable lifestyles including sexual success. Most studies have found that parents are an important resource to prevent substance abuse in adolescents. Expressing strong negative attitudes is very important yet it appears that many parents do not believe that such messages have any influence on young people. The research on what works with young people has tended to focus on measures aimed at the policy supply side such as enforcement of minimum drinking age laws, detecting and deterring sales to underage young people, increasing prices and prioritising drink driving detection measures. Prevention programmes in schools are also important. Early identification of young people who are drinking and offering brief interventions to reduce risks has also shown to be an effective prevention strategy. *MEGAPOLES* is a network of 15 European capital cities (including Dublin) established in 1997 in recognition of the fact that they face similar public health challenges. A young people and alcohol project has been undertaken in 2002 and 2003 with the aim of developing and proposing future actions at city and regional level for addressing alcohol use among young people under 25. The Authority is participating fully in this programme with a view to conjoint action and learning with other cities.

Health Promotion:
A wide range of strategies underpins the health promotion agenda including the *Health Promotion Strategy 2000-2005,* the *Cardiovascular Strategy (1999),* the *Cancer Strategy (1996),* the *Health Strategy* (2001) and the *Primary Care Strategy* (2001). The health promotion programme targets settings, priority populations, and risk factors. It is important that health promotion works across a range of different settings; in the workplace, in health and community care, in prisons, in schools and colleges and delivers health promotion services on a range of topics including nutrition, tobacco management, mental health promotion, suicide prevention, physical activity and alcohol. Health Promotion played a key role in the Community Mobilisation projects in Kilcock and Carnew. . In schools, from September 2003 all post-primary schools will participate in the health education programme, Social Personal and Health Education (SPHE). This programme, involving one class period per week, is a response to concerns for the health and well-being of young people in relation to alcohol, smoking, exercise and the use of illegal substances. It is imperative that health promotion measures concerning alcohol consumption are integrated with other programmes so that the potential for cross cutting and multi sectoral work is realised. As is clear from Fig 3, there is a pressing need to integrate more fully the role of health promotion and develop the potential for multi sectoral working.

Fig. 3 Health Promotion Components

	Key Settings
i	School
ii	Youth Sector
iii	Community
iv	Workplace
v	Health Service
	Priority Population Groups
i	Children
ii	Young People
iii	Disadvantaged
iv	Older People
	Risk Factors & Lifestyle
i	Alcohol
ii	Tobacco Control
iii	Nutrition
iv	Exercise/Physical Activity

Overview of Evidence of Effectiveness of Interventions

Within the spectrum of alcohol use (from abstinence to dependence), a number of patterns of use can be described – mild, moderate, hazardous, harmful and dependent.

Since alcohol misuse is a multi-faceted problem it follows that interventions must represent a diverse mix. Evidence of effectiveness is crucial in order to ensure that resources and efforts expended by services are used to best effect. There are seven broad categories of interventions as follows:

- **Policy and legislative interventions**
- **Enforcement**
- **Prevention**
- **Screening and detection**
- **Brief interventions**
- **Detoxification**
- **Relapse prevention**

This section draws on a review of evidence on the effectiveness and cost-effectiveness of these seven categories. (5) The extent to which these interventions transfer between countries may be influenced by different cultural attitudes towards drinking.

1. *Policy and legislative interventions*: There is good and consistent evidence that fiscal policy (taxation) is effective in reducing total alcohol consumption, although estimates of the size of the effect are variable. What is clear is that fiscal policy affects all drinkers, not just problem drinkers, in terms of the higher prices to be paid for alcohol. Evidence suggests that the alcohol consumption of the heaviest 10% drinkers is not responsive to price increases but problem drinkers below this level do respond. The evidence relating to under-age and youth drinking is unclear.

Evidence relating to licensing controls is mixed.

Studies of advertising and alcohol consumption over time have failed to find a significant association, although this may be due to limited variation in advertising expenditure. Studies of advertising bans across countries have found an effect but this may be due to countries with low consumption being more likely to ban advertising. There is, however, stronger evidence to support the effect of advertising on children.

2 *Enforcement*: The best evidence of effectiveness relates to random breath testing for drink driving which has been shown to be effective in both Australia and America.

3. *Prevention*: Most of the effectiveness evidence relates to school-based interventions and provides relatively weak evidence of effects on knowledge rather than behaviour. Characteristics of programmes which appear to contribute to success are interactive delivery, parental or community involvement or peer involvement.

Mass media campaigns relating to alcohol, tobacco or illicit drugs show some effects on knowledge and attitudes but little on behaviour. However, it should be also acknowledged that the spend on media campaigns is far less than that on promotional advertising by the drinks industry.

4. *Screening and detection*: Although a number of screening questionnaires are available to detect alcohol misuse, their performance is extremely variable. For general screening purposes, AUDIT is more effective in detecting at risk, hazardous or harmful drinking while CAGE is superior for detecting alcohol abuse and dependency. These two tests perform better than other screening tests (for further information on AUDIT and CAGE see Glossary of Terms).

5. *Brief interventions:* The majority of studies have shown brief interventions to be effective in changing drinking behaviour and reducing alcohol consumption for at least 12 months in patients who are not alcohol dependent (for further information on brief interventions see Glossary of Terms)

6. *Detoxification*: The evidence supports the use of benzodiazepines as the first choice therapy on the basis of safety and effectiveness but the quality of studies is

(5) The main source used here is the summary of findings in Scottish Executive (2002) *Effective and Cost-Effective Measures to reduce Alcohol Misuse in Scotland: A Literature Review*, pp.1-3

not very high. Outpatient treatment is safe and effective for patients with mild to moderate symptoms. Where inpatient treatment is required, longer stays have not been demonstrated to increase effectiveness.

7. *Relapse prevention/rehabilitation*: Despite a lack of randomised-controlled trials, psychosocial interventions are considered to be effective. Pharmacological treatments are effective as adjuncts to psychosocial interventions.

Evidence of the cost-effectiveness in relation to the seven categories of interventions is varied. Of particular relevance, however, is the evidence that brief interventions have fairly low costs and have been shown to be cost-effective.

In relation to policy and legislative interventions and enforcement the Authority fully endorses the recommendations made by the Strategic Task Force on Alcohol and considers that their implementation would lead to a reduction in alcohol related harm. These recommendations include measures to:

- Increase alcohol taxes and use the additional Exchequer revenue to implement the recommendations of the report
- Establish a National ID card scheme for the entire population in such a manner that cards can only be used for proof of age purposes in connection with the sale of alcohol
- Maintain licensing measures which restrict greater availability of alcohol sale outlets (both on-licences and off-licences).
- Make provision in legislation for a Health Board, to have the right on public health grounds, to object to the granting of new licenses, license renewal, exemptions or to set specific conditions for licenses in their region
- Introduce random driver breath testing and promote high visibility enforcement
- Lower the blood limit to .50mg % in line with most other European countries.
- Lower the blood alcohol limit for provisional drivers to zero (this action is provided for in the Road Traffic Act 1994 but has not yet been enacted)

In this context, the Authority welcomes the recent introduction of range of measures, (a number of which are in line with recommendations of the Strategic Task Force on Alcohol on limiting harm in drinking environments), provided for in the Intoxicating Liquor Act 2003 which urgently address the public order and public health concerns arising from excessive alcohol consumption. The Authority will continue to give full support to and influence the agenda relating to legislation and enforcement.

Alcohol related problems cost Irish society approximately € 2.4 billion per year. These include costs such as healthcare, road accidents, alcohol related crime and lost productivity

Strategic Task Force on Alcohol, Interim Report, 2002

Current Response in the Eastern Region

In describing the present services it is important to understand the policy backdrop to their development. The 1945 Mental Treatment Act that remains in force today includes specific reference to addiction and its treatment. Alcohol abuse is a significant risk factor in suicide and compounds other factors in suicide. Alcoholic disorders accounted for 18% of all admissions to psychiatric hospitals in 2001 (14% of all admissions in the eastern region) (6)

Planning for the Future (1984) was the first major policy document to reflect the public health approach that the prevalence of alcohol related problems was related to consumption levels and patterns. It acknowledged that services were heavily weighted towards treatment, whereas internationally, the focus had moved to prevention. It recommended that each mental health sector team should develop a local alcohol service as part of a comprehensive psychiatric service with an emphasis on the provision of outpatient counselling.

In the eastern region a committee established in the late 1980s to consider the implications of *Planning for the Future* recommended that each service would cover two community catchment areas, have a small number of beds available for those people who required inpatient treatment and that a consultant psychiatrist would have responsibility for the overall planning and delivery of alcohol services. As part of the subsequent reorganisation of services, St Dympna's, a centralised and specialist alcohol service with both inpatient and outpatient facilities, was closed with the intention that its funding stream would be directed at the new community based services (O'Sullivan,2002).

The implementation of these recommendations have only been partially realised;-

- the facilities for inpatient and outpatient detoxification are inadequate and are not linked adequately to the community services
- the number of counsellors is significantly inadequate
- no management structure was put in place
- the links between the counselling services and the psychiatric services are tenuous.
- links generally between the alcohol services and the other health and social services are weak
- the counselling pillar has evolved without adequate capacity, support or link to the main organisational structures.

Planning for the Future had warned against a 'separatist approach' in treating alcohol problems because of the tendency of such specialisation to exclude primary care and other community health and social services.

In relation to the present services it is important to acknowledge that there is a strong skill and expertise base on which to build. The Authority also recognises the dedication and commitment of staff working, managing and supporting these services.

There are 29 providers of alcohol treatment services in the eastern region that provide services for problematic and dependent drinkers. These services represent a mix of statutory and voluntary agencies, provide a wide range of different approaches for both drinkers and concerned persons affected by drinking. They include in-patient, out-patient and residential treatment. The services also provide a range of different responses including assessment, counselling (individual, group and family), crisis intervention counselling, detoxification, advice, aftercare, relapse prevention, community education and mobilisation and referral to other services. There are 20 counselling staff employed across the three Area Health Boards working to the ten community care areas (for a full list of these services see Appendix 1). It is not widely recognised that the counselling service is available not only to clients with alcohol problems but also to provide support to family members.

While the alcohol treatment services provide primarily tertiary services, there is also a diverse range of programmes and initiatives that respond to alcohol issues at primary and secondary levels (a list of these is included in Appendix 3)

(6) Daly, A., Walsh, D., (2003) Activities of Irish Psychiatric Services 2001, Health Research Board, pp. 25, 53

Recent initiatives

In addition to existing service provision, it is important to acknowledge that innovative programmes are being developed as part of an on-going response to alcohol misuse. The following are examples of programmes in the primary care, hospital and community settings. Results from these programmes indicate positive beneficial effects and they also have the potential for cost-effective replication.

Alcohol Aware Practice Study

The Alcohol Aware Practice pilot study was initiated by the Irish College of General Practitioners (ICGP) in association with the Department of Health and Children in September 2002. The purpose was to train GPs in effective intervention for patients and their families who present with a wide range of alcohol problems. The other aims of the study included :

- the involvement of the GP and all practice staff in brief intervention and referral
- the random screening of patients for alcohol problems
- the categorisation of patients as low risk or no risk, hazardous, harmful or dependent
- the familiarisation of GPs with the AUDIT questionnaire
- the creation of a greater awareness of alcohol problems in general practice

Ten sites, one in each health board area, were involved in the pilot. The three sites in the eastern region were in Churchtown (East Coast Area Health Board), Donaghamede (Northern Area Health Board) and Baltinglass, (South Western Area Health Board). The Authority provided additional funding to the Baltinglass pilot for an alcohol counsellor for six hours per week to enhance the GP interventions with patients. Results from the pilots have been very positive.

Community Mobilisation Project

The community mobilisation approach involves supporting a community to develop and deliver its own responses to alcohol problems. The South Western Area Health Board initiated a community mobilisation project in Kilcock, County Kildare, in the latter part of 2002. The East Coast Area Health Board also undertook a community mobilisation project in Carnew, Co. Wicklow. The purpose of these projects was to raise awareness of the impact of alcohol on the community and to empower the community to respond to alcohol issues in their own area. Similar projects have since been introduced in Rialto, and Dun Laoghaire. The community mobilisation approach offers potential for changing community attitudes to the impact of alcohol

General Hospitals

Following on from research in the Mater Hospital on the incidence of alcohol problems in inpatient admissions and attendances at A&E, guidelines for the management of alcohol problems in a general hospital have been developed by Dr John Sheehan. These guidelines, contained on a simple information sheet, have been piloted in the Mater Hospital. They will help to increase awareness of alcohol problems, improve detection and provide straightforward instructions on how to manage alcohol problems in a hospital setting.

Homeless Detox Unit

A new detox unit, funded by the South Western Area Health Board and managed by the Dublin Simon Community has been set up to help homeless people with alcohol problems. This is part of the *Homeless Strategy* to improve access to health and social services since homeless people continue to encounter difficulties in accessing services. It consists of an 8-bed unit in the existing Simon emergency shelter. The unit is staffed by a five-member nursing team supported by volunteers. The programme lasts up to three weeks and consists of a medical detox as well as group work and one-to-one key-working. Every effort is made by staff to find options for each individual and source the best possible 'move on' in order for him/her to continue a life free from alcohol.

A Policy and Implementation Framework for the Future

In the past decade there has been a sea change in the appreciation of the impact of alcohol and drug misuse in society generally, and in health, psychiatric and social services in particular. The increase in alcohol consumption presents significant demands and challenges to developing effective responses. The Authority recognises that alcohol services require considerable development to address the wide-ranging needs of presenting clients. The development of services requires an immediate injection of resources, expansion in capacity, a clear structure of responsibility and management and a realistic framework for growth that is underpinned by robust research and evaluation. It is essential that services develop in a sequential and phased manner on a spectrum of prevention, early intervention, treatment, rehabilitation, support and training in a range of key settings.

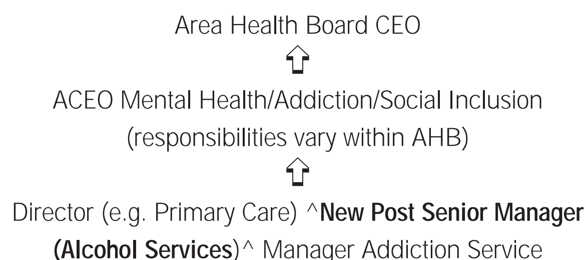
In 2004 the intention is to seek adequate funding to commission a mix of services in a diversity of settings based on an evidence based model of efficacy. The following are areas which the Authority would consider for priority attention.

- The Authority intends to commission the development of screening and brief interventions in two key settings – primary care and general hospitals. This is one of the few areas to emerge frequently in research efficacy and the intention is to build on the pilot projects already described in both these settings. Discussion will take place with the ICGP on a partnership arrangement to roll out the Alcohol Aware Practice study in a range of GP practices in the region and to recruit counsellors to add that extra dimension as was done in the Baltinglass pilot. The implementation of the Primary Care Strategy, the three areas identified as the initial implementation sites and the current Primary Care GP partnerships provide immediate potential to improve the response to alcohol misuse at primary care level.
- Similarly, the Authority will work with the Acute Hospitals to replicate the Mater Hospital Pilot in a targeted number of hospitals in 2004. The objectives of the Mater Study included quantifying the prevalence of alcohol abuse and dependence amongst inpatients; comparing the clinical utility of three well validated popular screening tools used to detect alcohol misuse; examine the current practice amongst medical staff in the identification and treatment of alcohol misuse and assess the impact of a single brief intervention by a trained alcohol counsellor on subsequent use of alcohol services.
- The Authority intends to put in place a remedial capital programme for the refurbishment of health board treatment facilities including residential facilities. The physical deterioration of some of the present services is the legacy of the relative neglect of the alcohol services, the lack of priority given to this area and the consequent lack of funding.
- The role of health promotion to interface with alcohol services on the continuum of prevention and training will be strengthened by commissioning specific projects in 2004. The role of health promotion with young people to address alcohol experimentation and misuse will be extended, the potential to cross cut with tobacco cessation projects and cardiovascular projects will be maximised.
- The Authority is acutely aware of the need to address the geographic imbalance in the provision of treatment services – specifically the need for additional detoxification facilities both on an outpatient and inpatient basis and the need for additional counsellors. Some areas are better served than others and there is a need to ensure a more even spread of these services. Developments in treatment services will include support for families affected by alcohol problems.
- The Authority will actively explore the need for improved mechanisms for access by those with alcohol problems and their families to information and services. This will include examination of the potential role for a telephone helpline and support for existing voluntary providers who provide information and support to people with a range of social problems.
- The Authority intends to commission training across the health and social service sectors to enhance awareness of problematic alcohol use and enable staff to develop screening and detection.
- In respect of existing screening programmes the

Authority will evaluate service responsiveness following referral and, if necessary, seek to supplement services so as to ensure that, where appropriate, fast track assessment, detox and treatment services are available. The capacity of services to respond quickly and flexibly in line with clients motivation is a critical issue. Similar monitoring arrangements will be built into new screening and primary care initiatives.

Organisational Issues:

The present fragmented structure of the alcohol services requires urgent attention. It is imperative that a structure is put in place with clear responsibility and accountability at both an operational and policy level. The Authority recognises that the issue of where alcohol services are best located at national level is currently under discussion. However, on a regional basis the emerging view is that alcohol services be located within the addictions framework and community setting. There is an urgent need for the sustained and phased development of alcohol services supported by an transparent and accountable infrastructure that enables integration across care groups and takes account of relevant policy initiatives – e.g. Mental Health Act 2001, the Primary Care Strategy, the Cardiovascular Strategy. It is clear from research that there are significant overlaps between primary care and alcohol, presentations at A&E departments and alcohol, disability and alcohol, homelessness and alcohol, mental health and alcohol, addiction and alcohol and suicide/self harm and alcohol. There is real potential to intervene positively but an appropriate infrastructure must be put in place to support service development. Irrespective of where the alcohol services are located, it is clearly important that they interface with all care groups and we begin to 'alcohol proof" commissioning, planning, development and policy across health and social services. To overcome fears that the development of alcohol responses will divert existing resources from other services, we will ring fence any additional resources on a transparent basis. The appointment of Senior Managers that have responsibility for the implementation of this Action Plan in the three Area Health Boards with requisite administration support reporting to an Assistant Chief Executive Officer (ACEO) can be the beginning of building the necessary infrastructure and ensuring transparency in resource allocation and service delivery.



Implementation

The implementation stage of any plan is crucial and too often insufficient thought is given to implementation. We have been fortunate in working with a wide range of people across the statutory, voluntary and community sector in drawing up this plan and we intend to replicate this range of expertise in the implementation stage. A working group will therefore be established, led by the Authority with representation from key players in the Area Health Boards, primary care, hospitals, voluntary and community sector. It is intended that this will be a small working group that is task-orientated and will consult and involve other parties as required by specific actions. The implementation process will be broken down into realistic timescales with the emphasis on immediate steps that have an impact on meeting priority objectives. It will also be important to establish a robust monitoring and review process so that we can be certain resources are being targeted in the most effective manner.

Resources:

The Authority intends to seek additional resources from the Department of Health and Children to enhance the current provision. This is put forward in an environment that is financially challenging and where there are constraints on recruitment of staff to the health and personal social services. However, if we are to address the problems in relation to alcohol consumption and dependency that we now face, we must have the resources and capacity necessary to create the range and level of services that are vital. In the context of additional funding requirements for the health response to alcohol misuse, it is important to note that alcohol products generate approximately €1.5 billion in revenue to the state through excise duties and VAT receipts. (7)

(7) Strategic Task Force on Alcohol, Interim Report, p.23

Proposed Alcohol Services Developments 2004 - 2005

Development	**Details**	**Resources required**
Primary Care	Alcohol Aware Practice Initiatives in 7 Primary Care sites (3 Implementation sites plus 4 GP Partnerships).Potentially this could interface with over 160 GP's and their teams. This initiative will also replicate access to counsellor hours.	€700,000
Hospital Screening	Replicate Mater Hospital Pilot in each Area Health Board	€100,000
Maternity Screening	Introduce screening brief intervention programme as a pilot in one maternity hospital	€30,000
Capital refurbishment	Existing premises	€250,000
Additional alcohol treatment services	To include a range of professional staff in each Area Health Board	€1,800,000
Training for Health & Social Service staff	Roll out of programme of training for frontline staff across health and social services – input of health promotion and education officers	€100,000
Appointment of senior managers	Senior manager for alcohol services in each Area Health Board and administrative support with identified responsibility for implementation	€250,000
Improvements in service information and access	Feasibility as to the need for freephone helpline for advice, information and support and or improved liaison and support for voluntary services	€100,000
Additional funding to voluntary sector		€200,000
Evaluation/Research	Initiate evaluation/research programme	€100,000
Community Mobilisation Programmes	Expand	€100,000
Total		**€3,730,000**

Conclusion

This report provides an overview of the harmful effects of increased alcohol consumption in Ireland and has outlined the research evidence on the most effective interventions to address this issue. A series of implementation steps to achieve the necessary development of services in the eastern region has been outlined as has the need for a clear structure of responsibility, accountability and support.

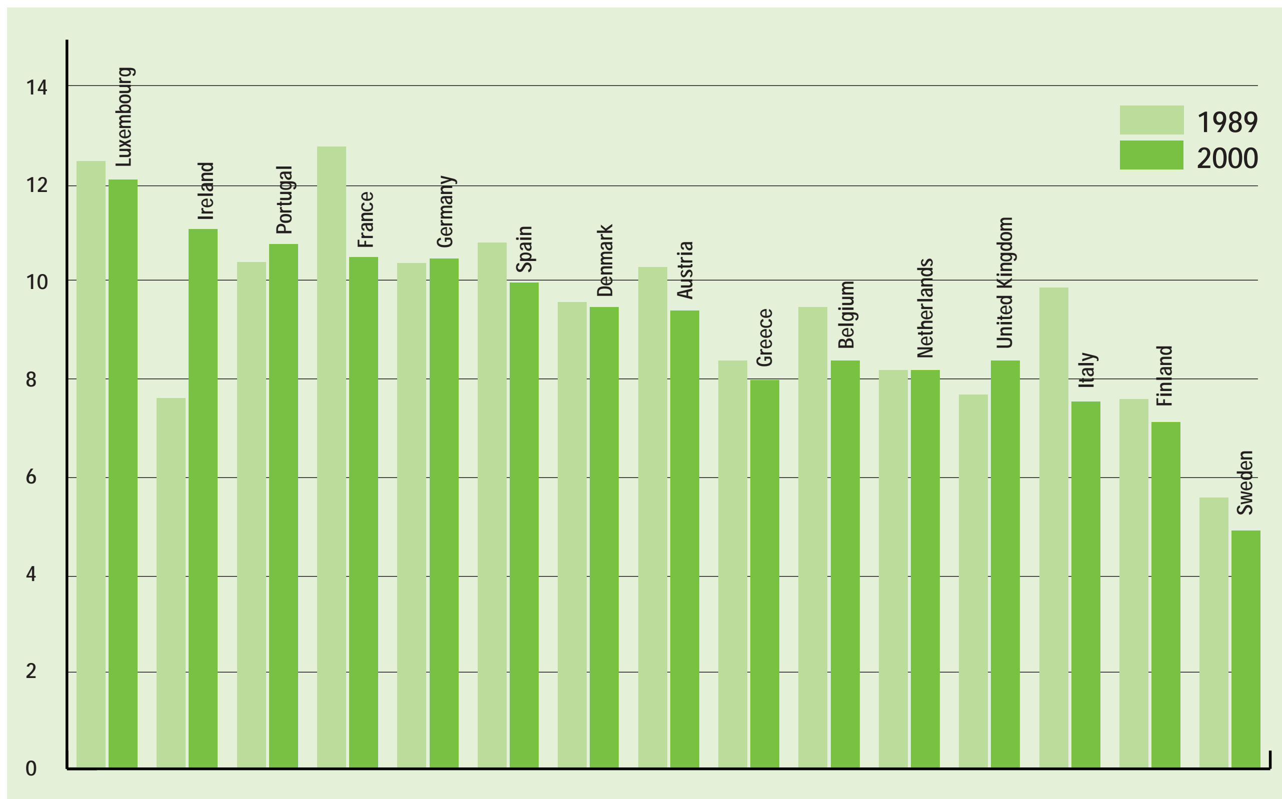
Recognising the complexity of the issues involved, the report does not purport to provide a comprehensive solution to achieving more sensible consumption of alcohol in the eastern region. Nor does it attempt to set over-ambitious targets. Rather it sets out a programme of actions that the Authority considers are capable of implementation but which will make a significant difference to the quality of life of many individuals and families affected by the consequences of alcohol misuse. It sets out realistic steps along the path of enhancing services, over the two- year period 2004 - 2005 and we intend to review progress at the end of 2004.

Acknowledgments

A number of people have been instrumental in compiling this report. Specifically we would like to thank members of the alcohol review working group i.e. Rolande Anderson, Joe Barry, Ciaran Browne, Vivienne Fay, Paudie Galvin, Derval Howley, Breda Lawless, Sheila Lyons, John O'Connor, Clodagh O' Sullivan, Lesley Proudfoot, Marian Rackard, Martin Rogan, Stephen Rowan, Jim Ryan, Shay Smith.
The significant input of members of the Board of the Authority, both individually and collectively, and the priority attached by the Board to addressing this issue has been very important in the development of the report.

Appendix 1:

Alcohol consumption per capita, in litres of pure alcohol, 1989-2000, EU Countries



Source: Strategic Task Force on Alcohol: Interim Report (2002)

Appendix 2:
Alcohol Treatment Services*

Service	Location
Addiction Counselling Service	Blanchardstown
Alcohol Treatment Unit	Baggot Street Hospital
Barrymore House	North Circular Road
The Cluain Mhuire Service	Newtownpark Avenue, Blackrock
Community Addiction Counselling	Health Centre, Patrick Street Dun Laoghaire
Community Alcohol Services	Glen Abbey Centre, Belgard Road, Tallaght
Drug Treatment Centre Board	Pearse Street
EHB Clinic	Castle Street
Inchicore Community Drug Team	Emmet Road, Inchicore
Newcastle Hospital	Greystones, Co. Wicklow
Rialto Community Drug Team	St. Andrew's Community Centre, Rialto
Stanhope Centre	Lower. Grangegorman
Talbot Centre	Upper. Buckingham Street
Ballymun Youth Action Project	Balcurris Road Ballymun
Clanwilliam Institute	Clanwilliam Terrace, Grand Canal Quay
Coolmine House	Lord Edward Street
Cuan Mhuire	Athy, Co.Kildare
Dublin Counselling & Therapy Centre	Upper Gardiner Street
Mater Dei Counselling Centre	Mater Dei Institute, Clonliffe Road
Merchant's Quay Project	Merchant's Quay
Rutland Centre	Knocklyon Road, Templeogue
St. John of God Hospital	Stillorgan
St. Patrick's Hospital	Steeven's Lane
St. Vincent's Psychiatric Hospital	Fairview
Teach Mhuire	Lower Gardiner Street
Teen Counselling	Quarryvale, Clondalkin
Teen Counselling	Raheen Park, Springfield

***Adapted from the Directory of Drug and Alcohol Services, Department of Health and Children**

Appendix 3

Other responses to Alcohol Issues in the Eastern Region

These include:

- Drug and alcohol awareness programmes under the Social, Personal Health and Education (SPHE) initiatives in secondary schools
- The Department of Health and Children has initiated a 'Think Before You Drink: Less is More' campaign aimed at tackling binge drinking patterns. This consists of television and radio adverts and associated promotional material (e.g. pens, calendars, mouse mats).
- There are many youth initiatives aimed at providing alternatives to drinking by adolescents within different communities. These are often targeted at areas of high deprivation.
- No Name Clubs offer alternatives to young people to the pub culture
- All colleges and universities must now produce a policy on alcohol and there is evidence that the active implementation of such policies is effective
- There has been an appreciable effort to change social attitudes related to drink driving and the Gardai have continued to step up their detection of drink drivers
- The Irish College of General Practice has initiated an Alcohol Aware Practice project aimed at upskilling GPs in the diagnosis and response to detected problematic alcohol use
- Emergency Departments in the hospitals in the eastern region are planning to introduce an injury surveillance system which includes alcohol as a causal factor
- Most Emergency Departments in the eastern region are participating in the National Parasuicide Register which includes the reporting of the presence of alcohol during a parasuicide attempt
- Some Emergency Departments of acute general hospitals within the eastern region are employing specialised nurses and protocols to respond to alcohol misuse.
- A community mobilisation project was initiated during 2002 in Kilcock, Co. Kildare, which was aimed at raising awareness of the impact of alcohol on the community. Similar projects have since been introduced in other communities.
- A number of organisations have been formed to bring together groups concerned with the lack of response to tackling alcohol in Ireland (e.g. Irish National Alliance for Action on Alcohol)
- There are many voluntary organisations which provide support to those directly and indirectly affected by the impact of alcohol on partners and families (e.g. Alcoholics Anonymous, Samaritans, Women's Aid, Rape Crisis Centres)
- Employee Assistance Programmes in corporations now contain a strong element of dealing with alcohol related problems such as absenteeism.

In other sectors, there are initiatives underway. These include:

- A Code of Advertising Standards for Alcoholic Drinks
- A proposed ban on alcohol advertising before 9pm (British or satellite channels not covered).
- A series of responsible serving initiatives undertaken by the Vintners Federation

Appendix 4

Staged Developments of Alcohol Services by Area Health Board

South Western Area Health Board

- Dedicated Manager plus administration support reporting to ACEO
- Primary Care roll out of Alcohol Awareness Programme to GP partnerships and other health care professionals
- Replication of Mater Hospital Pilot
- Additional Alcohol Treatment services modelled on service in Tallaght
- Recruitment of multi disciplinary team to provide holistic assessments
  (include counsellors, psychiatrist, social worker, family therapist, GP sessions, child care workers, registrar)
- Strategic input of health promotion to provide education/prevention/awareness programmes across the spectrum of health and community services and in schools, colleges cross cutting with other initiatives
- Workplace initiatives
- Support and funding of community/voluntary initiatives
- Support to the Irish National Alliance for Action on Alcohol (INAAA)

Northern Area Health Board

- Dedicated Manager plus administration support reporting to ACEO
- Primary Care roll out of Alcohol Awareness Programme to GP partnerships and other health care professionals.
- Replication of Mater Hospital Pilot
- Development of community care area based alcohol service to complement current service in Stanhope Street and St. Vincent's Hospital, Fairview
- Recruitment of multi disciplinary team to provide holistic assessment to include counsellors, psychiatrist, social worker, family therapist, GP sessions, child care workers, registrar)
- Workplace initiatives
- Support and funding of community/voluntary initiatives
- Strategic input of health promotion to provide education/prevention/awareness programmes across the spectrum of health and community services and in schools and colleges cross cutting with other initiatives

East Coast Area Health Board

- Dedicated Manager plus administration support reporting to ACEO
- Primary Care roll out of Alcohol Awareness Programme to GP partnerships and other health care professionals.
- Replication of Mater Hospital Pilot
- Recruitment of multi disciplinary team to provide holistic assessments
  (include counsellors, psychiatrist, social worker, family therapist, GP sessions, child care workers, registrar
- Strategic input of Health Promotion to provide education/prevention/awareness programmes across the spectrum of health and community services and in schools and colleges cross cutting with other initiatives
- Workplace initiatives
- Support and funding for community/voluntary initiatives
- Strategic input of health promotion to provide education/prevention/awareness programmes across the spectrum of health and community services and in schools and colleges cross cutting with other initiatives

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Glossary of Terms

Brief Interventions:
A brief intervention is a time-limited intervention focusing on changing patient behaviour with respect to alcohol consumption through motivational counselling. There are more studies in this area than for any other intervention. A brief intervention has been defined as having five essential steps:

- assessment of drinking behaviour and feed back;
- negotiation and agreement of goal for reducing alcohol use;
- familiarisation of patient with behaviour modification techniques;
- reinforcement with self help materials;
- follow up telephone support or further visits.
- Brief interventions are mainly used to reduce alcohol consumption in people drinking above recommended levels but who are not dependent.

AUDIT
Alcohol **U**se **D**isorder **I**dentification **T**est
This involves ten questions to detect hazardous drinking.

CAGE
An internationally used assessment instrument for identifying problems with alcohol based on responses to the following questions.

C Have you ever felt you should **C**ut down on your drinking?
A Have people **A**nnoyed you by criticising or complaining about your drinking?
G Have you ever felt bad or **G**uilty about your drinking?
E Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye opener)?

Eastern Regional
Health Authority

Údarás Réigiúnda
Sláinte an Oirthir