



Understanding Alcohol Misuse in Scotland

HARMFUL DRINKING

Final Report

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Background and acknowledgements

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. NHS QIS does this by setting standards, by monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

NHS QIS gratefully acknowledges the work of the Scottish Emergency Department Alcohol Audit (SEDAA) steering group for overseeing the project from its inception to the publication of this report.

NHS QIS also gratefully acknowledges the work carried out by the Scottish Trauma Audit Group (STAG), its audit co-ordinators and particularly the emergency department staff who contributed to the growing evidence base on alcohol problems in Scotland.

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Priority Recommendations*

NHS Boards and their partner organisations should:

- have in place support and training on managing alcohol-related presentations in the emergency department, with support and advice from NHS Education for Scotland. This should include training in the use of screening tools and more generally address staff attitudes. The effectiveness of this should be monitored. (1, 2, 7, 9, 13)
- routinely use alcohol screening tools to identify patients where there is a risk of alcohol-related harm to health. The SEDAA steering group recommends the short, validated Paddington Alcohol Test (PAT). (2, 12)
- provide readily accessible information materials (eg health advice literature) to give to patients in the emergency department. However, alcohol screening is only effective where there are adequate, appropriate services for onward referral. Staff should be aware of these services and confident that referral will lead to positive outcomes for patients. (3, 4, 5, 10, 15, 16)
- adopt a consistent, integrated approach between emergency departments and their stakeholders, for example alcohol services, mental health services and the police. Where information and data are shared, this should be in accordance with local policies and national guidelines. (4, 5, 7, 8, 10, 11, 16)

Making it happen

We also recommend that information on alcohol-related presentations to emergency departments should continue to be collected and the results acted on. A follow-up audit, or similar, should be conducted to review the implementation and outcomes of these and other recommendations. (6, 9, 14)

* Priority recommendations should be cross-referenced with the detailed recommendations contained throughout the report. These are given in brackets.

1 Introduction

In 2002, the Scottish Executive published its Plan for Action on Alcohol Problems, which outlined a commitment to consider the development of standards for the treatment and management of people with alcohol problems.¹ NHS QIS contributed to this plan by establishing a short-life Alcohol Advisory Group to consider how best to support the implementation of key policies and the improvement of alcohol services. The group met between May 2004 and January 2005 and comprised membership from a range of disciplines, including policy makers, service planners, and service providers from voluntary and statutory organisations.

As part of the Alcohol Advisory Group's work, a discussion forum involving key alcohol service providers was held in December 2004. The event provided us with a better understanding of where to focus future work. One area where there was little information was on alcohol-related attendances at Scottish emergency departments. To address this, in September 2005, NHS QIS established the Scottish Emergency Department Alcohol Audit (SEDAA) steering group to provide expert advice and formulate an appropriate contribution to the growing evidence base on alcohol problems in Scotland. The membership of both groups is given in Appendix 1.

The aim of the SEDAA steering group was two-fold: to describe the burden of disease and provide descriptive epidemiology on alcohol-related presentations to emergency departments in Scotland (for terms of reference see Appendix 2). To facilitate this, the group commissioned the Scottish Trauma Audit Group (STAG) to undertake a two-part programme of work.

- Part one focused on gathering the evidence necessary to inform and shape the SEDAA steering group's work, including:
 - a survey of emergency department staff attitudes towards the management of patients with alcohol-related problems
 - a survey of staff views on the use of alcohol screening tools, and
 - the compilation of a directory of locally-available alcohol services.
- Part two comprised a programme of work identified by members of the steering group as requiring particular attention. A series of five time-limited audits was devised and focused on:
 - the size of the overall problem
 - alcohol-related assaults
 - alcohol-related self-harm
 - the use of intravenous B vitamins, and
 - alcohol and young people.*

This report summarises the findings of this work which was carried out in 15–20 mainland emergency departments between October 2005 and June 2007 (for a list of participating sites see Appendix 3). Examples of good practice are highlighted and recommendations for further work and service improvements are made.

* All reports are now available at www.nhshealthquality.org

1.1 Definitions

Alcohol consumption ranges from responsible and sensible drinking to heavy consumption and dependence. Current recommendations suggest that men should not consistently drink more than 3–4 units of alcohol per day and women should drink no more than 2–3 units of alcohol per day.² Most health agencies also recommend 2 or 3 alcohol-free days every week.

A unit of alcohol contains 8g (10ml) of ethanol. This is approximately the amount of alcohol contained in half a pint of 3.5% beer or lager, or one 25ml pub measure of spirits. A small (125ml) glass of average strength (12%) wine contains 1.5 units.³

Table 1: Classification of alcohol misuse

Binge drinker	There is no commonly accepted definition but the Scottish Health Survey uses the criterion of drinking more than twice the recommended daily benchmark on a person's heaviest drinking day (more than 8 units for men and more than 6 units for women). ⁴
Harmful drinking (ICD-10)	A pattern of drinking that causes damage to physical (eg to the liver) or mental health (eg episodes of depression secondary to heavy consumption of alcohol). ⁵
Hazardous drinking / At-risk drinking	<p>A pattern of use that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user. The term is used currently by the World Health Organization but is not a diagnostic term in ICD-10.⁶</p> <p>The term hazardous drinking is also used loosely to cover those who have experienced minimal as opposed to serious harm.³</p>
Alcohol dependence	A cluster of physiological, behavioural and cognitive phenomena. A central characteristic is the desire (often strong, sometimes perceived as overpowering) to drink alcohol. ⁵

Harmful drinking is defined in the International Classification of Diseases (ICD-10).⁵ While the diagnostic criteria require that actual damage should have been caused to the mental or physical health of the user, for the purposes of the group, and unless stated otherwise, harmful drinking is used throughout to refer to any emergency department attendance where alcohol was considered to be a contributory factor.

1.2 Study limitations

Identifying patients for whom alcohol is a contributory factor in their presentation to a busy emergency department is not straightforward and may not be entirely reliable. While the data collected by STAG offer a robust and contemporary account of alcohol-related presentations to emergency departments, they are likely to underestimate the full extent of such attendances for the following reasons.

- Data collection was restricted to mainland Scottish emergency departments which had STAG local co-ordinators in post.
- The data do not reflect seasonal variations, for example peaks in attendances during holiday periods.
- Recording of alcohol-related admissions, alcohol-related violence, etc, relied on nursing and medical staff deciding on whether alcohol was a contributory factor and then detailing this.



2 The prevalence of misuse

Misuse of alcohol is associated with a wide range of health and social problems, including damage to physical health, accidental injury and violence, mental illness and crime. Both in terms of direct costs (eg hospital services and the criminal justice service) and indirect costs (eg loss of productivity and the impact on family and social groups), the impact of alcohol misuse on the Scottish economy is substantial. Current research suggests that this figure is in excess of £1 billion a year,⁷ and evidence indicates that the problem is getting worse.

- Consumption of alcohol in the adult population has increased by 23% over the last 10 years.⁸
- One in 30 deaths is directly related to alcohol, with alcohol-related death rates more than tripling in the past 25 years.⁸
- The most recent Scottish Health Survey shows that, *in a usual week*:
 - 27% of men and 14% of women drink in excess of the recommended weekly number of alcohol units
 - 63% of men and 57% of women in Scotland are drinking in excess of recommended daily levels at some point, and
 - 37% of men and 28% of women are 'binge' drinking during that time.¹⁰
- In 2005 there were 2,372 deaths in Scotland attributed to alcohol, a slight rise from 2004 (2,339) and an increase of 15% since 2001. More men than women died of alcohol-related conditions in 2005 (males 1,663; females 709).⁹

In terms of both the impact on hospital staff and the additional resources required to treat its consequences, misuse of alcohol places a significant burden on the health service in Scotland. Ninety per cent (35,211) of all alcohol-related discharges in Scotland in 2005–06 were the result of an emergency admission, and a further 4% of all general hospital discharges over the same period were diagnosed with an alcohol-related condition.⁹ Moreover, further research indicates that Scotland's rates of mortality due to cirrhosis of the liver are among the highest in Western Europe, although similar increases in cirrhosis mortality can be observed across Britain as a whole. In this respect, although the steepest increases were observed in British men and women between 45 and 64 years of age, notable increases in liver cirrhosis were observed at all ages.¹⁰

Within this context, emergency departments in Scotland are regularly in the front line in responding to the needs of those who are ill or injured as a result of alcohol. Whilst its work is rightly focused on treating the immediate consequences of a patient's presenting complaint, the emergency department may also provide an ideal setting for the opportunistic use of alcohol screening tools. The extent to which such screening is undertaken as part of the routine treatment and management of harmful drinkers, however, is addressed in this report. Due consideration is also given to the various complicating factors which may hinder the ability of staff to administer these tools, including patients who are intoxicated, the personal safety of staff and the additional workload for the department.

2.1 STAG survey: the management of alcohol-related presentations

In Autumn 2005, STAG conducted a survey of emergency department staff views on the management of patients with alcohol-related problems. Local audit co-ordinators carried out a 15 minute interview with six emergency department staff members from a cross section of nursing and medical staff (see Appendix 4). In total, 88 staff members from 15 mainland hospital emergency departments were interviewed.

Emergency department staff attitudes to alcohol misuse

Staff responses to the question 'What do you consider to be an alcohol problem?' were predominantly grouped in one or more of the following categories:

- the volume of alcohol consumption
- the negative health consequences of drinking too much
- being addicted or having withdrawal symptoms
- interference with daily life, and
- binge drinking.

Most staff members made reference to more than one of these factors in their response, for example the physical and social consequences of alcohol misuse.

- Staff estimated that alcohol was a component in 30% of presentations.
- In respect of these presentations, 85 (97%) of those interviewed agreed that alcohol-related attendances created additional problems for the department, including:
 - the increased workload (the need for observation, peaks in attendance, etc)
 - the potentially aggressive behaviour of intoxicated patients, and
 - the increased prevalence of certain conditions and associated difficulties with assessment and treatment, for example psychiatric problems.

The management and treatment of patients in the emergency department

- Seventy-eight (87%) staff reported at least one instance where a patient had asked for help with a drinking problem, although it was acknowledged that spontaneous help-seeking is a rare occurrence.
- Only 15 (17%) staff felt that they would be unable to raise the issue of alcohol with a patient who had not specifically asked for help.
- Examples of the type of support that staff felt they were able to provide to patients included:
 - giving advice about the health consequences of alcohol misuse
 - advising the patient to contact their GP, and
 - providing contact details for alcohol support services.

When asked how often patients were referred for further treatment and support, staff members' responses were low overall. The most prevalent answer was referral to a psychiatric liaison nurse, with an average of four referrals per month by each staff member. The variation between staff members was high, however, and ranged from no referrals to a maximum of 80 referrals per month (see Appendix 4). Data were not collected on the availability of local alcohol services in respondents' NHS board areas.

Finally, staff members were asked about the availability of alcohol-related leaflets for patients in the emergency department.

- Overall, 52 (60%) staff had access to this material, of which 22 (42%) reported never giving the leaflets to patients.
- While less than half of the staff members (43%, 38) believed such leaflets were effective, most mentioned the fact that such information is only effective with motivated patients.

Findings

From this work it is evident that emergency department staff acknowledge the range of possible causes and consequences of alcohol misuse. In terms of the impact of alcohol-related attendances on the functioning of the department, staff were most likely to highlight aggressive or violent patient behaviour and a perceived increase in the staff's workload. A small number of those interviewed questioned the appropriateness of the emergency department setting for providing ongoing care for patients with alcohol problems.

Where patients specifically ask for help with their drinking, or where the staff member raises the subject, they are most frequently given information on harmful drinking, advised to contact their GP or provided with details of locally available services. However, given the potentially large volume of presentations on any day and further complicating factors, such as the patient's level of intoxication, it was noted that it is not always possible to provide this level of support and advice.

Although a lack of awareness of external service provision may explain the low rate of referral to such services, this survey suggests that staff do not routinely adopt a proactive role in the management of alcohol-related presentations to emergency departments. This may be further complicated by differences in the availability of services between geographical areas and problems associated with access, such as waiting times and the provision of services out-of-hours.

2.2 STAG survey: staff attitudes towards alcohol screening

In Autumn 2005, STAG undertook a questionnaire-based survey of the attitudes and opinions of emergency department staff in relation to alcohol screening tools. Of the 869 medical and nursing staff surveyed, 360 (41%) questionnaires were returned.

Part one of the survey addressed staff members' perceptions of the prevalence and detection of alcohol-related problems in the emergency department. This included questions about:

- the use of interventions as part of a duty of care
- support for the implementation of screening tools in the department
- confidence in screening patients for alcohol misuse
- their view of the benefits for patients of screening, and
- staff attitudes towards specific screening tools.

The second part of the survey focused on staff perceptions of a range of alcohol screening tools, including the Alcohol Use Disorders Identification Test (AUDIT), the Fast Alcohol Screening Test (FAST) and the Paddington Alcohol Test (PAT)—the definitions and applications of these tools are given in Appendix 5.

Findings

Staff who participated in this survey were generally positive about the use of screening tools within the emergency department. Their aggregated responses highlight a number of recurrent themes in relation to the feasibility of screening within this setting:

- shorter screening tools are most likely to be adopted routinely
- more detailed tools, however, are likely to yield more accurate results
- staff indicated that, given appropriate training, they would be willing and confident to use screening tools, and
- concerns were expressed about the accuracy of patient responses in relation to screening tools generally.

There is a large evidence base indicating that appropriate screening helps the detection and treatment of alcohol problems. In light of this, and in consideration of the factors outlined above, the PAT offers emergency department staff a short, validated and effective tool for routine use in the department.

Crucially, however, the administration of a screening questionnaire should serve only as a basis for discussing alcohol problems. The final aim of screening should be to improve outcomes for patients via referral to external service providers, for example treatment and counselling.

2.3 Alcohol services directory

A regularly updated comprehensive directory of alcohol services and accommodation should be developed for the benefit of NHSScotland staff, patients and their families, friends and carers.

Source: NHS QIS Health Technology Assessment Report 3 (HTA)¹¹

As part of its programme of work, and in response to the recommendations of the NHS QIS Health Technology Assessment Report 3 (HTA)¹¹, STAG began to compile a directory of locally available alcohol services across Scotland. This project was initially undertaken in collaboration with the former Scottish Executive Health Department (SEHD), but was later adopted into the wider strategic work of the SEHD's Alcohol Policy Team.

Members of the team carried out a comprehensive survey of all available alcohol services in Scotland and compiled a directory of the information. Without dedicated input it was apparent that the information-gathering process was time consuming, not exhaustive and rapidly became out of date.

Recommendations

- 1 Emergency departments should ensure that systems are in place to review and address staff attitudes, skills and training on a regular basis.
- 2 Emergency departments should consider greater use of screening tools, specifically the Paddington Alcohol Test (PAT). Programmes should be developed for increasing awareness of these tools, including for the introduction of screening. We recommend a feasibility study to consider the practicalities of this and to quantify any resource requirements. This should be supported by national standards.
- 3 For screening to be worthwhile, there need to be services which are appropriate, reliable and receptive for onward referral of identified patients.
- 4 A comprehensive directory of alcohol services should be developed, maintained and regularly updated. We recommend that this directory becomes the responsibility of the local alcohol services.
- 5 Emergency departments should ensure that clear communication is maintained with local alcohol services and that up-to-date literature is available within the emergency department to give to patients.



3 The audits

Summary of findings and recommendations

3.1 Alcohol and the size of the problem

The aim of the audit was to determine the extent to which alcohol is a contributory factor in patient attendances at emergency departments in Scotland. The audit sought to answer two key questions:

- 1 How many attendances are related to alcohol?
- 2 What are the principal presenting complaints and subsequent care pathways of these patients?

Fifteen mainland emergency departments took part in the audit over 10 separate days during October and November 2005.

- A total of 21,214 patients were seen in participating emergency departments during the audit period; alcohol was considered to be a contributory factor in 2,228 (11%) cases.
- The majority of alcohol-related attendances were by men and women aged 20–29 years old. In all age groups, men (71%) were significantly more likely to have an alcohol-related factor in their presentation than women (29%).
- One in four (27%) patients had a recorded history of alcohol-related problems in their past medical history.
- The busiest time for alcohol-related presentations was between midnight and 4am on a Saturday morning. Four and a half times more patients presented during these 4 hours than at the same time during the rest of the week.
- The most common presenting complaint was some form of alcohol-related injury (53%) followed by intoxication (23%).
- The majority of patients (56%) were discharged following treatment, although a third (32%) were admitted to hospital, including to a medical ward (53%), orthopaedic (15%), general surgical (14%) or short-stay ward (12%).
- Only two patients in the study were screened in the emergency department using a recognised alcohol screening tool.

Recommendations

- 6 A core minimum data set for alcohol should be developed and implemented to ensure accurate recording and inform service development and future strategic development (see Appendix 6).
- 7 Clarity is required regarding the role of emergency department staff in the treatment and management of patients with alcohol problems. Emergency department staff have not, in the past, had a recognised role in opportunistic health screening. Any change in this will require to have the support of the emergency medicine community.



Violence Reduction Unit (VRU)

The police-led VRU was established in 2005 to work on long-term solutions for tackling violent crime in Scotland, including violence in schools, the workplace, on streets and in the home.

Based at Strathclyde Police Force Headquarters, the VRU works closely with other professionals, including social workers, health experts and academics. Together, they share information to develop a better understanding of violent behaviour and use this knowledge to create strategies for tackling violent behaviour and to challenge attitudes in society.

For more information:

www.actiononviolence.co.uk/aov/21.81.21.html

Cardiff Violence Prevention Group

This multi-agency group, comprising representatives of the police, licensing magistrates, victim support, local authority, local emergency department consultants and consultant community liaison psychiatrists came together to tackle violent crime.

Research showed that the NHS had an obvious role to play in tackling both the causes and effects of violence in the community. In particular, the group concluded that emergency departments can contribute distinctively and effectively to violence prevention by working in partnership with crime and disorder reduction units and by sharing, electronically wherever possible, simple anonymised data about precise location of violence, weapon use, assailants and day/time of violence.

For more information:

www.crimereduction.homeoffice.gov.uk/cardif.htm

3.2 Alcohol and assaults

The aim of the second audit was to determine the number and nature of patients' attendances to emergency departments in Scotland as the result of an assault, and to identify the degree to which alcohol was a contributory factor in such cases. Sixteen mainland emergency departments took part in the audit over a 6-week period between March and April 2006.

- A total of 90,432 patients were seen in participating emergency departments during the audit period, with assaults comprising 3,281 (4%) attendances. The majority of attendances (78%) involved men.
- Every day in Scotland approximately 110 assaults require treatment at an emergency department. Seventy-seven (70%) of these are related to alcohol.
- Alcohol-related violence in the street was the most commonly documented location of an assault.
- By gender, however, the most commonly documented location for women (36%) was in the home.
- There were 85 documented cases of verbal or physical abuse of emergency department staff during the audit period. Most instances of this type of abuse involved people who had been drinking.

Recommendations

- 8 Emergency departments should ensure that effective systems are in place for sharing data across organisations and between agencies. These should follow national guidelines and local policies.
- 9 Incident reporting systems must be in place and rigorously monitored. This is a corporate responsibility. We recommend increasing staff awareness and training in the use of these, with appropriate monitoring through NHS Boards' clinical governance frameworks.
- 10 The number of alcohol-related assaults in the home is of considerable concern and we support initiatives to quantify the incidence of domestic abuse and the relation with alcohol. Emergency departments should ensure that up-to-date information is available for victims of domestic abuse and have local arrangements in place for onward referral and support.



3.3 Alcohol and self-harm

The aim of the third audit was to determine the number and nature of attendances to emergency departments in Scotland as a result of self-harm, to record the involvement of alcohol in the presentation and to report on the patient's subsequent management. Sixteen mainland emergency departments took part in the audit over a 10-week period between September and November 2006.

- A total of 172,700 patients were seen in participating emergency departments during the audit period, with self-harm attendances comprising 3,454 (2%) attendances.
- Forty-three per cent of self-harm attendances were under 30 years of age, including 461 (15%) patients who were younger than 20 years of age.
- More than half (62%) of men and 50% of women reported consuming alcohol prior to their attendance at the emergency department. A further 27% of men and 19% of women cited alcohol as the trigger for self-harming.
- Only 14 (0.4%) patients were assessed using an alcohol screening tool.
- A preliminary psychosocial assessment was carried out in 96% of cases.

Recommendations

- 11 Emergency departments should establish and maintain close liaison with their local mental health services. As a minimum this should include clear policies for referral and follow-up of this group of patients. To be effective, this also requires an integrated approach within mental health services themselves.
- 12 Emergency departments should have policies in place to ensure that all patients who self-harm undergo psychosocial assessment and have an alcohol history taken.*

* This should be considered alongside the Scottish Government's report Closing the Gaps.¹² The report recommends that the systematic use of alcohol misuse screening tools should be part of psychosocial assessment. Implementation of the recommendations in the report forms part of the wider strategic work outlined in Delivering for Mental Health¹³ (DfMH), and local DfMH groups should monitor this.



**NHS Quality Improvement Scotland Evidence Note 20:
Screening tools, detoxification and vitamin supplementation for alcohol dependence.¹⁵**

Published in October 2007, Evidence Note 20 provides key recommendations for the treatment of patients with a recognised alcohol dependency. These include:

- Fast Alcohol Screening Test (FAST) is an appropriate screening tool in the emergency department for detecting people with alcohol dependence who may need detoxification.
- High dose parenteral thiamine (vitamin B) is an effective treatment for Wernicke's encephalopathy. Vitamin supplements should be prescribed where nutritional deficiencies are likely.

For more information:

www.nhshealthquality.org

3.4 Alcohol and the use of intravenous B vitamins

The aim of the fourth audit was to determine the number and nature of attendances to emergency departments in Scotland by people with serious alcohol-related problems. The audit also sought to establish the extent to which parenteral B vitamins (PBVs) were administered as part of the routine treatment and management of this patient group. Fifteen mainland emergency departments took part in the audit over 14 days from February–April 2006.

Vitamin supplements are given to dependent drinkers to prevent conditions like Wernicke's encephalopathy, which is caused by thiamine (vitamin B) deficiency. If left untreated, this condition can lead to an irreversible form of brain damage known as Korsakoff's syndrome. The medicine used to treat patients with serious alcohol problems comes in two forms: thiamine is commonly prescribed for oral administration or can be administered parenterally in Pabrinex® (two ampoules containing sterile aqueous solution which are mixed prior to administration). The safety and efficacy of PBVs has been established and its use as a preventative treatment recommended.^{3,14}

The findings of the STAG audit suggest that the rate of vitamin B administration in Scottish emergency departments is low overall. It is possible that a number of patients who were being admitted from the emergency department received vitamins following admission and that this was not captured in the data collection process.

- A total of 27,901 patients were seen in participating emergency departments during the audit period, with attendances by patients with serious alcohol problems comprising 985 (3.5%) attendances.
- Of those patients presenting at the emergency department with a serious alcohol problem, almost three quarters (73%) were men.
- Gastrointestinal complaints and trauma were the most prevalent presenting complaints.
- The recommended PBV dose of four vials (two pairs of ampoules) was administered in less than half (44%) of emergency department-based treatments.
- Nearly all patients (93%) for whom PBV administration was planned, and a high percentage of those receiving PBVs in the emergency department (80%), were admitted to a ward.

Recommendations

- 13 Emergency departments should ensure that all staff are aware of the benefits of administration of parenteral vitamins in patients with serious alcohol problems. Local protocols for the administration of parenteral vitamins in patients with serious alcohol problems should be in place.



The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2006 found that:

- among those who had ever had an alcoholic drink, a third (33%) of 13 year olds and over half (54%) of 15 year olds reported at least one instance when they had drunk five or more drinks on the same occasion over the past 30 days
- fourteen per cent of 13 year olds and 36% of 15 year olds reported consuming an alcoholic drink in the last week. In both age groups, girls were slightly more likely to have done so than boys, and
- of those who reported consuming alcohol in the last week, the mean number of units consumed was 13 units for 13 year olds and 16 units for 15 year olds.

Source: SALSUS, 2006¹⁶

3.5 Alcohol and young people

The aim of the fifth audit was to determine the extent and nature of alcohol-related attendances to emergency departments in Scotland by young people (aged 17 years or less). Data were also collected on the role of alcohol and other substances in the young person's presentation and their subsequent treatment and management. Three paediatric hospital emergency departments and 18 mainland emergency departments took part in the audit over a 5-week period between April and June 2007.

- Twenty-seven per cent (34,441) of attendances during the audit period were by young people. Almost two per cent (1.9%, 669) of these attendances were by young people where alcohol was a factor in their presentation.
- 633 (98%) patients were aged 13 to 17. The remainder (15, 2%) were between 8 and 12 years of age.
- Males (54%) were slightly more likely to present to the emergency department having consumed alcohol than females.
- The median age of participants was 16 years.
- An average of 13 alcohol units were consumed in the 24 hours before attendance.
- Twenty-two per cent of young people reported misusing substances other than alcohol in the 24 hours before attendance, of which ecstasy (29%) was the most prevalent.
- Fourteen per cent of presentations were associated with self-harm. The prevalence rate was significantly higher in females (20%) compared to males (9%).

Recommendations

- 14 Further study of this group is needed to provide greater accuracy of data.
- 15 Local arrangements should be put in place to ensure straightforward referral to reliable services.
- 16 As part of the development of a comprehensive directory of alcohol services, specific information on services for young people should be included.



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BETTER HEALTH, BETTER CARE:

ACTION PLAN

"Help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care"



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4 Next steps

Launched in December 2007, Better Health, Better Care is the Scottish Government's 5-year strategy for a healthier Scotland.¹⁷ The plan outlines the Government's commitment to tackling increases in alcohol-related illness and mortality in Scotland, and includes:

- publishing a national strategy on alcohol abuse in Spring 2008
- providing an additional £85.3 million over 3 years to reduce alcohol-related harm, and
- promoting health interventions that help people stop or reduce their drinking. These include:
 - increasing access to follow-up treatment and support for those who need it
 - increasing the number of alcohol nurses in acute and primary care settings, and
 - systematising the use of screening and brief interventions to identify early harm to health caused by hazardous and harmful drinking.

Screening and brief interventions in particular are addressed through the Government's Health Improvement, Efficiency and Governance, Access and Treatment (HEAT) target for alcohol:

Health Improvement 4: Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN Guideline 74 by 2010/11.

The target concentrates on measuring NHS board areas' contribution over a 3-year period to tackling harmful drinking and alcohol dependence. Progress is measured through Boards' local delivery plans.

Policy development in this area offers a major opportunity to reduce the burden of alcohol misuse in Scotland. However, careful attention needs to be paid to translating this into concrete local implementation plans that bring about practical, tangible changes in service practice and service provision. In setting out the key recommendations that should be expected of emergency departments and their partner organisations, we hope that our work will inform this process and provide a valuable contribution to an issue of national significance.

Appendix 1

Group membership

Alcohol Advisory Group

Dr Jonathan Chick (until January 2005)
Consultant Psychiatrist
NHS Lothian

Mr Colin Cook
Head of Substance Misuse Division
Scottish Executive Health
Department

Ms Joyce Craig
Senior Health Economist
NHS Quality Improvement Scotland

Mrs Mary Cuthbert (until January 2005)
Alcohol and Smoking Policy Team
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Professor John Davies
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Dr Lesley Graham
Associate Specialist in
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NHS National Services Scotland

Ms Lindsay Liddle (until September 2004)
Alcohol and Smoking Policy Team
Scottish Executive Health
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Dr John Loudon (Chair)
Mental Health Advisor
NHS Quality Improvement Scotland

Dr Ian Pullen
Medical Advisor
Scottish Executive

Dr Peter Rice (since December 2004)
Consultant Psychiatrist
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Dr Maggie Watts
Consultant in Public Health Medicine
NHS Ayrshire & Arran

Scottish Emergency Department Alcohol Audit (SEDA)

Steering Group

Ms Diana Beard

Project Manager
Lothian University Hospitals Division

Mr Ian Davidson

Alcohol Liaison Nurse
NHS Lothian
Scottish Chair ANSA

Mr Arron Duncan

Superintendent
Tayside Police

Dr Lesley Graham

Associate Specialist in
Public Health Medicine
NHS National Services Scotland

Dr Alasdair Gray

Consultant in Emergency Medicine
NHS Lothian

Mr Gary Kerr

Consultant in Emergency Medicine
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Dr Alan Lannigan

Consultant in Emergency Medicine
NHS Ayrshire & Arran

Mr Jack Law

Chief Executive
Alcohol Focus Scotland

Dr John Loudon

Mental Health Advisor
NHS Quality Improvement Scotland

Ms Lindsay Liddle (until March 2006)

Policy Officer
Scottish Government

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Appendix 2

Terms of reference (SEDAA steering group)

Aim

To describe the burden of disease and provide descriptive epidemiology for all alcohol-related presentations to the emergency departments in Scotland.

Objectives

- To examine the flow of people through emergency departments in Scotland, how they are assessed and managed, and how local agencies are involved in their further care.
- To identify the range of local alcohol services available via the collaborative work of STAG and the SEHD.
- To agree and direct the scope and remit of the audit work.
- To provide advice and expertise on a continuing basis.
- To monitor progress of the audit work.
- To oversee the production of a national report.

Scope

INCLUSIONS

The audit work will be conducted in emergency departments in all NHS board areas in Scotland as feasibly possible.

The audit will be applicable to all people presenting with an alcohol component to their condition.

EXCLUSIONS

Any investigation which would be subject to a research ethics approval process.

Constraints

Availability of accessible information in emergency departments.

Availability and time commitment of the Alcohol Steering Group members.

Capacity within healthcare settings (eg primary care).

Assumptions

Appropriate representation on the Alcohol Steering Group.

Appropriate participation in this work by all members of the Alcohol Steering Group.

Alcohol Steering Group will have access to all appropriate literature and documentation.

Reporting

Alcohol Steering Group Chair and Audit Project Manager to provide progress reports to the Alcohol Steering Group and NHS QIS Senior Management Team every 4 months.

Deliverables

A completed report detailing the findings of the audit work and resulting recommendations.

Timescales

Key milestone dates for this audit work.

- Alcohol Steering Group to meet every 4–6 months for the working life of the project, unless otherwise stated.
- Report on audit work of alcohol-related presentations to emergency departments, with recommendations, no later than March 2008.

Appendix 3

Participating emergency departments

Ayrshire & Arran

Crosshouse Hospital, Kilmarnock

Forth Valley

Falkirk and District Royal Infirmary

Stirling Royal Infirmary

Grampian

Aberdeen Royal Infirmary

Royal Aberdeen Children's Hospital*

Dr Gray's Hospital, Elgin

Greater Glasgow and Clyde

Western Infirmary, Glasgow

Glasgow Royal Infirmary

Victoria Infirmary, Glasgow

Southern General Hospital, Glasgow

Royal Alexandra Hospital, Paisley

Inverclyde Royal Hospital, Greenock

Royal Hospital for Sick Children, Yorkhill*

Highland

Raigmore Hospital, Inverness

Lanarkshire

Wishaw General Hospital

Monklands District General Hospital, Airdrie

Lothian

Royal Infirmary of Edinburgh

St John's Hospital, Livingston

Royal Hospital for Sick Children, Edinburgh*

Tayside

Perth Royal Infirmary

Ninewells Hospital, Dundee

* Participated in audit 5 only.

Appendix 4

STAG survey of service provision – tables

Table 1: Number of interviewed staff members according to grade

Grade	Number	Percentage	Years of experience (median)
Medical grades			
Consultant	12	13.6	11.0
Specialist registrar/ Senior house officer III	15	17.0	3.5
Senior house officer	14	15.9	0.5
Nursing grades			
G grade	14	15.9	18.0
F grade	2	2.3	12.5
E grade	14	15.9	6.0
D grade	13	14.8	2.0
Unknown	4	4.5	9.0
Total	88	100	7.0

Table 2: Reported number of referred patients each month by service

	Minimum	Maximum	Mean
Psychiatric liaison nurse	0	80	3.8
Alcohol liaison nurse	0	80	3.2
General practitioner	0	24	3.2
Community-based agencies (eg social work)	0	28	1.5
Voluntary organisations (eg Alcoholics Anonymous)	0	16	1.0
Other services	0	2	0.3

Appendix 5

Alcohol screening tools

Screening tools vary in the type of alcohol misuse they are effective at detecting, for example alcohol dependence or hazardous drinking. Most screening tools have some degree of error and some patients who screen positive will not be problem drinkers.

Questionnaires based on a quantity/frequency approach consist of one or more simple questions about the frequency of drinking and the typical amount of alcohol consumed on an average drinking day. These types of screening tools are useful at detecting hazardous drinking and identifying patterns of excessive consumption. SIGN Guideline 74³ addresses the use of screening tools in the emergency department and recommends the Paddington Alcohol Test (PAT) or Fast Alcohol Screening Test (FAST).

Fast Alcohol Screening Test (FAST)¹⁸

FAST is a modified version of the Alcohol Use Disorders Identification Tool (AUDIT). It was developed in response to an identified need for a short and easy-to-score questionnaire for use within busy environments such as the emergency department. The tool consists of four items and can be completed by either the patient or a staff member in under 1 minute.

FAST

For the following questions please circle the answer which best applies.
(1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits)

1. MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

Never Less than Monthly Monthly Weekly Daily or almost daily

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never Less than Monthly Monthly Weekly Daily or almost daily

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

Never Less than Monthly Monthly Weekly Daily or almost daily

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No Yes, but not in the last year Yes, during the last year

Score questions one to three: 0, 1, 2, 3, 4.

Score question four: 0, 2, 4

Paddington Alcohol Test (PAT)¹⁹

PAT detects patterns of hazardous drinking and binge drinking. The instrument also records daily alcohol intake. It is designed for selective use where alcohol is considered to be a contributory factor in the presentation.

The 1 minute Paddington Alcohol Test (PAT)

Please complete for all A&E patients where there is any suspicion of alcohol abuse e.g. falls, assaults, head injuries, gastrointestinal problems, 'unwell', fits, blackouts, collapse, insomnia, sweating, palpitations, chest pain, gout, rashes, depression, overdoses and especially REPEAT ATTENDANCE perhaps with unexplained symptoms and DELAYED ATTENDANCE, perhaps as intoxicated at the time of incident.

Remember the ELDERLY presenting with: falls, confusion, incontinence and self-neglect.

1. Quite a number of people have times when they drink more than usual; what is the most you will drink in any one day?

(Note: 1 unit = 8g alcohol. Pub measures, in units, are given in brackets; home measures of 'singles' for example are often x3):

Beer/lager/cider	Pints (2)	<input type="text"/>	Cans (1.5)	<input type="text"/>
Strong Beer/lager/cider	Pints (5)	<input type="text"/>	Cans (4)	<input type="text"/>
Wine	Glasses (1.5)	<input type="text"/>	Bottles (9)	<input type="text"/>
Fortified Wine (Sherry, Martini)	Glasses (1)	<input type="text"/>	Bottles (12)	<input type="text"/>
Spirits (Gin, Whisky, Vodka)	Singles (1)	<input type="text"/>	Bottles (30)	<input type="text"/>
Total units/day =		<input type="text"/>		<input type="text"/>

2. If you drink more than 8 units/day (for men), or 6 units/day (for women), is this at least once a week?

Yes = PAT +ve

No = Go to question 3

3. Do you feel your current attendance at A&E is related to alcohol?

Yes = PAT +ve

No = PAT -ve

Patients who are PAT +ve should be offered specific alcohol advice and managed according to a local protocol.

Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed by the World Health Organization as an identification and screening tool. The questionnaire has been widely tested in a range of settings and has shown good reliability and validity. In addition to its primary role in identification, the AUDIT has also been shown to be effective in assessing severity of alcohol problems, including dependence. The AUDIT has 10 items and takes 5–10 minutes to complete.²⁰

Appendix 6

Example core data set

If no alcohol has been consumed within the previous 24 hours, then the rest of the questions are not relevant.

Questions	
1	Has the patient consumed alcohol in the previous 24hrs? 0 = No 1 = Yes
2	What type of alcohol was consumed? (will require more than one box to allow for more than one known type) 0 = not documented 1 = spirits 2 = beer/lager 3 = cider 4 = fortified wines 5 = wines 6 = alcopops 7 = combination – not further specified (NFS)
3	How many units? (need to have alcohol wheels or comprehensive drop-down menu) Wine should be taken as average strength (12%) and average size (bottle or glass) unless you have further information. If beers etc/pints are NFS use the lowest alcohol content (ie not one that is 'a low alcohol' drink): average can size = 440ml and average bottle size = 330ml. A 'bottle of cider NFS' is 2 litre and regular strength.
4	How was the alcohol obtained? 1 = given 2 = bought for patient 3 = bought by self 4 = from house (including at party) 5 = other → specify
5	Are there alcohol-related problems in the patient's PMH? 0 = No 1 = Yes
6	Was patient referred to alcohol liaison nurse? 0 = No 1 = Yes
7	If no, was patient referred to another alcohol support service? 0 = No 1 = Yes → specify
Possibly for inclusion:	
	Has the patient been verbally abusive? 0 = No 1 = Yes
	Has the patient been physically abusive? 0 = No 1 = Yes

Appendix 7

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