Challenges of caring for people with alcohol dependence admitted to acute care in hospitals.

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Uganda Alcohol Policy Conference

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Conflicts of Interests

Personal:

- Additional Hours payments from Hull University Hospitals Teaching NHS Trust related to supporting the Alcohol Care Team

- University of Hull receives funding from NIHR Y&H CRN – Specialty Lead for Mental Health

- Co-Lead NIHR – HS&DR funded project (ProACTIVE) – evaluating the impact of Alcohol Care Teams in England

- Visiting appointment at IOPPN, King's College London

Member of the following expert groups:

- UK Alcohol Clinical Guideline, ACT National Working Group, NICE QS, RCPsych Faculty Exec

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- **Acknowledgements**

- Members of the Alcohol Care Team Clinical Competency Consensus Panel

University of Hull

- Dr Chao Huang & Amy Porter

University of Kent

- Prof Simon Coulton

IOPPN, King's College London

- Prof Colin Drummond & Dr Emmert Roberts

University of Southampton

- Prof Julia Sinclair

Background

- Every UK Government Alcohol Strategy has targeted a reduction in alcohol-related hospital admissions (2004, 2008, 2012)
  - Department of Health, Reducing Alcohol Admissions Team

- Recognition that specialist alcohol treatment is an effective policy strategy associated with reductions in liver morbidity, mortality and hospital admissions

- Prevalence of those in need of treatment interventions has remained relatively static over the last decade

- Limited access to specialist treatment (12-15%): concerns the in-need population are not able to receive the care and support they need

- Access to treatment further restricted by government policy introduction of Health Social Care Act 2012 – closure of inpatient units -

- Recognised non- specialist hospital admissions ~500k in 2003/4 to 1,260k in 2018/19

Conceptual model of harm (WHO, 2014)

》 Complex interaction between the individual, social, cultural and biological factors
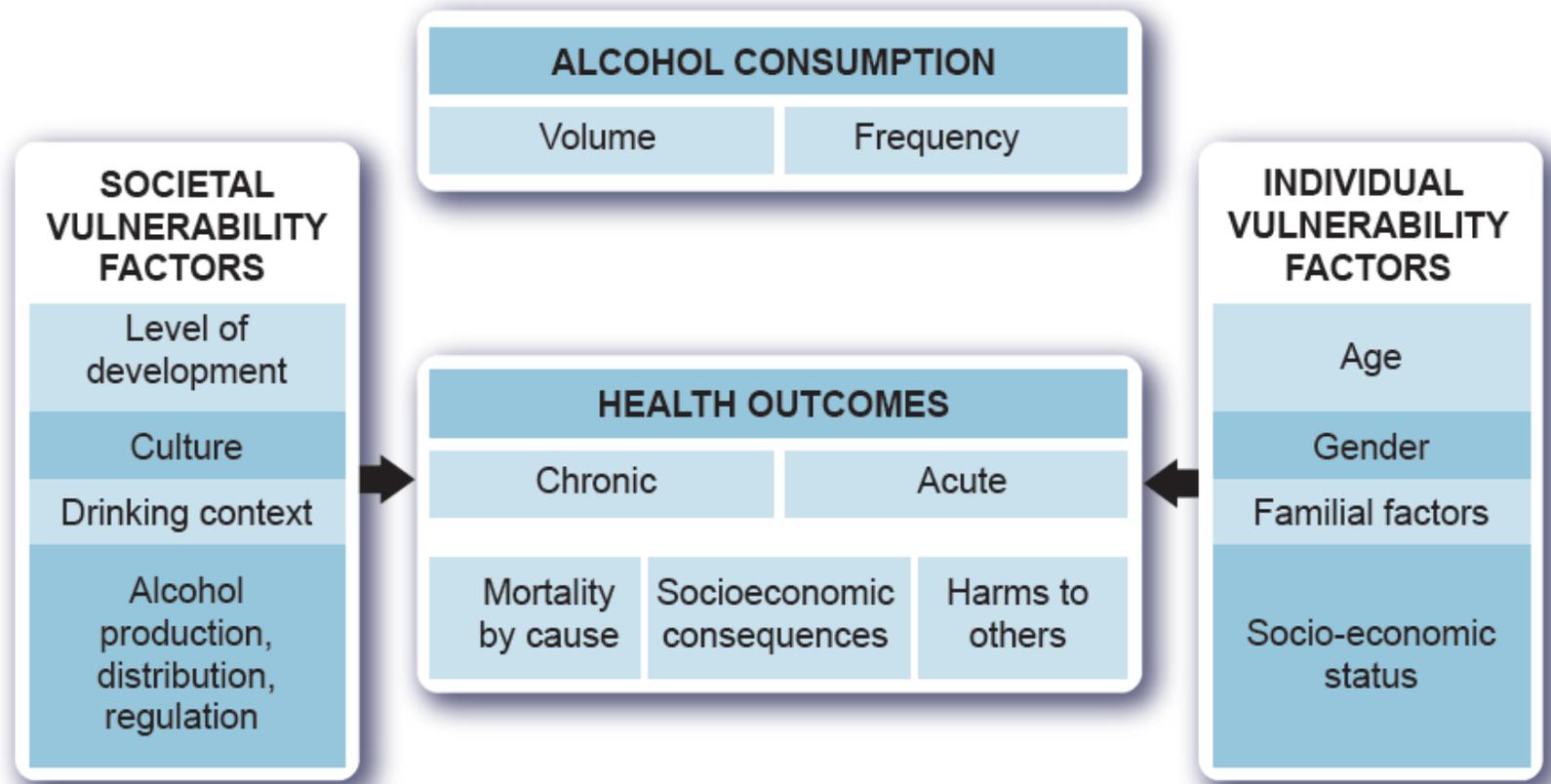
Public Health Surveillance

- National Prevalence Estimates – General Household Survey – Adult Psychiatric Morbidity Survey (Includes; AUDIT (Saunders et al, 1993) SADQ (Stockwell, 1983)
  - In need population 3.1% Harmful/dependent drinker 600,000 -1million

- National Drug Alcohol Treatment Monitoring System (NDTMS) - England
  - Severity of use DDD
  - Treatment contact
  - Treatment type
  - 75,000 – 80,000 per annum

- Hospital admission – Routine hospital – diagnostic codes

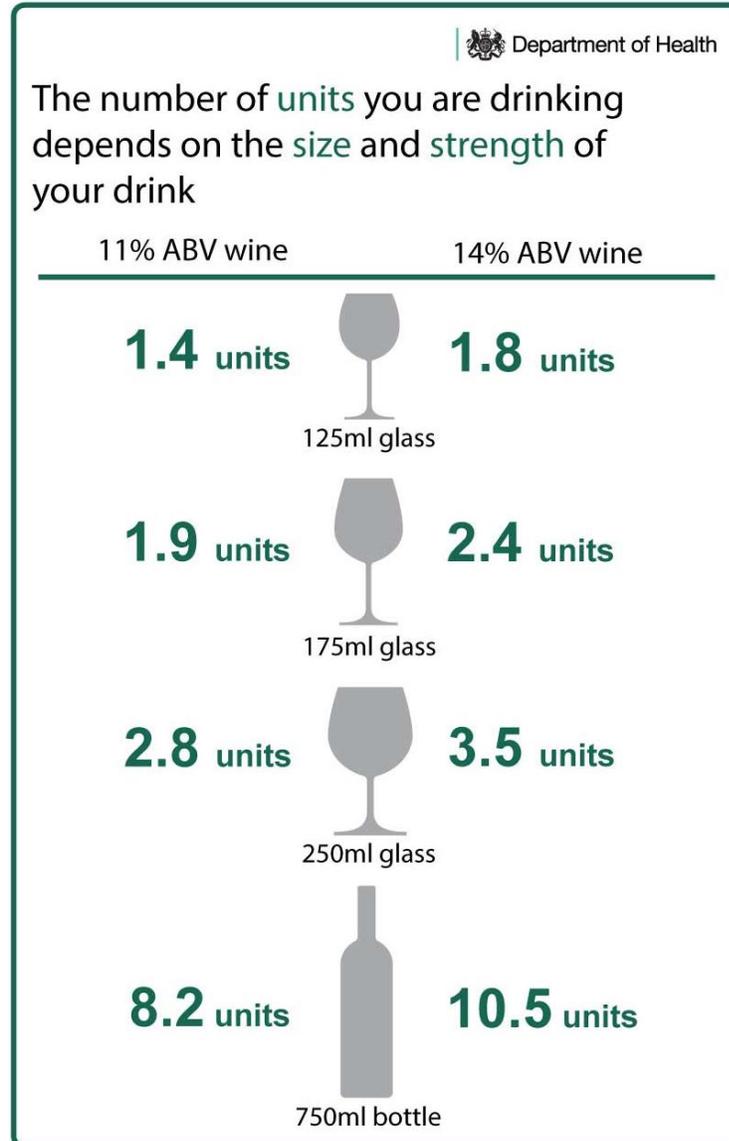- 1.26 million alcohol related hospital admissions

Context

- Alcohol treatment system needs to be; *accessible, efficient* & *well resourced*

- Health service use – individual and behavioural factors:
  - Individual's characteristics
  - Attitudes about health services
  - Ability to access care
  - Perceived and assessed need

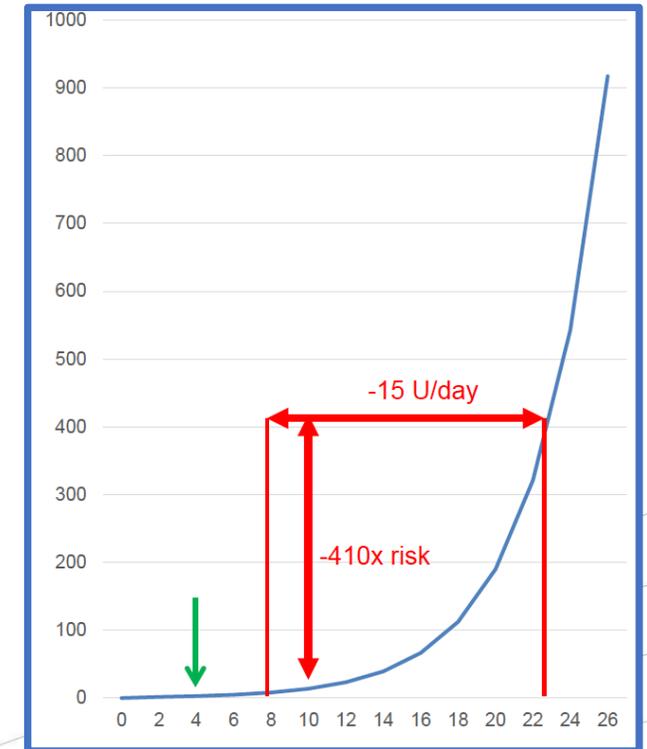- Unmet demand for treatment in one part of the system increases demand in another

(Babor, 2008; Rush & Urbanoski, 2019; Smart & Mann, 2000; Rautiainen 2019; Andersen, 1995; Ritter, 2019)
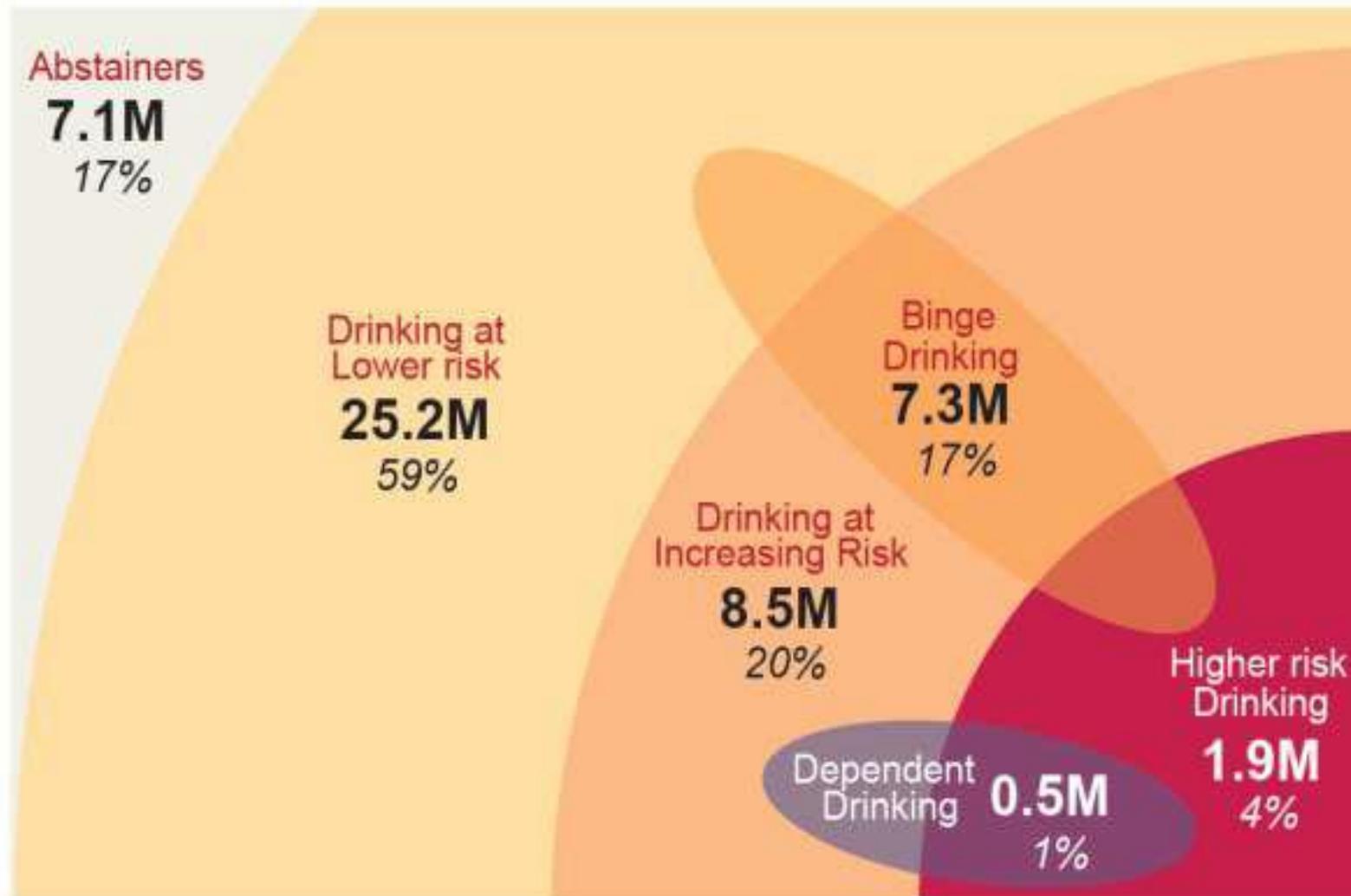
WHO drinking risk levels

	MALES UK units	FEMALES UK units
Risk levels of drinking		
Low risk	Up to 5	Up to 2.5
Medium risk	>5 – 7.5	>2.5 - 5
High risk	>7.5 – 12.5	>5 - 7.5
Very high risk	>12.5	>7.5
Risk on a single drinking day		
Low risk	Up to 5	Up to 2.5
Medium risk	>5 – 7.5	>2.5 - 5
High risk	>7.5	>5

Department of Health

The number of units you are drinking depends on the size and strength of your drink

11% ABV wine	14% ABV wine
1.4 units	1.8 units

125ml glass

1.9 units	2.4 units

175ml glass

2.8 units	3.5 units

250ml glass

8.2 units	10.5 units

750ml bottle

Risk of health harms by daily alcohol consumption (units). Drummond et al (2018)

-15 U/day
-410x risk

Who is the population?

Abstainers
7.1M
17%

Drinking at Lower risk
25.2M
59%

Binge Drinking
7.3M
17%

Drinking at Increasing Risk
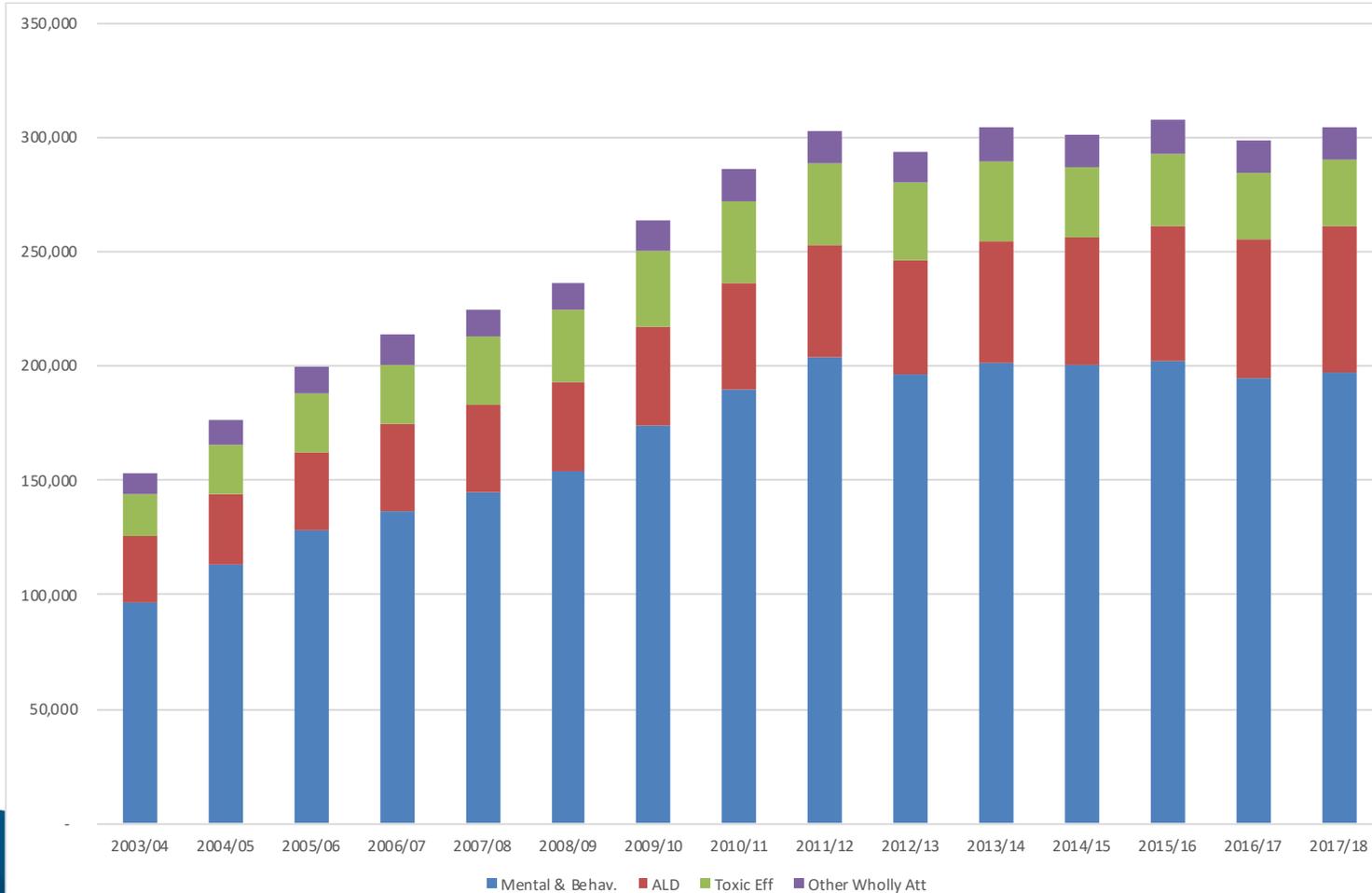8.5M
20%

Dependent Drinking 0.5M
1%

Higher risk Drinking
1.9M
4%

But hospital prevalence <10 x higher

Wholly Alcohol-related admissions 2003-2018 (PHE, 2019)

Total Admissions: 300k

- 21% = K70 - ALD
- 66% = F10 Men. Bev. ETOH
  - Acute Intox. 20%
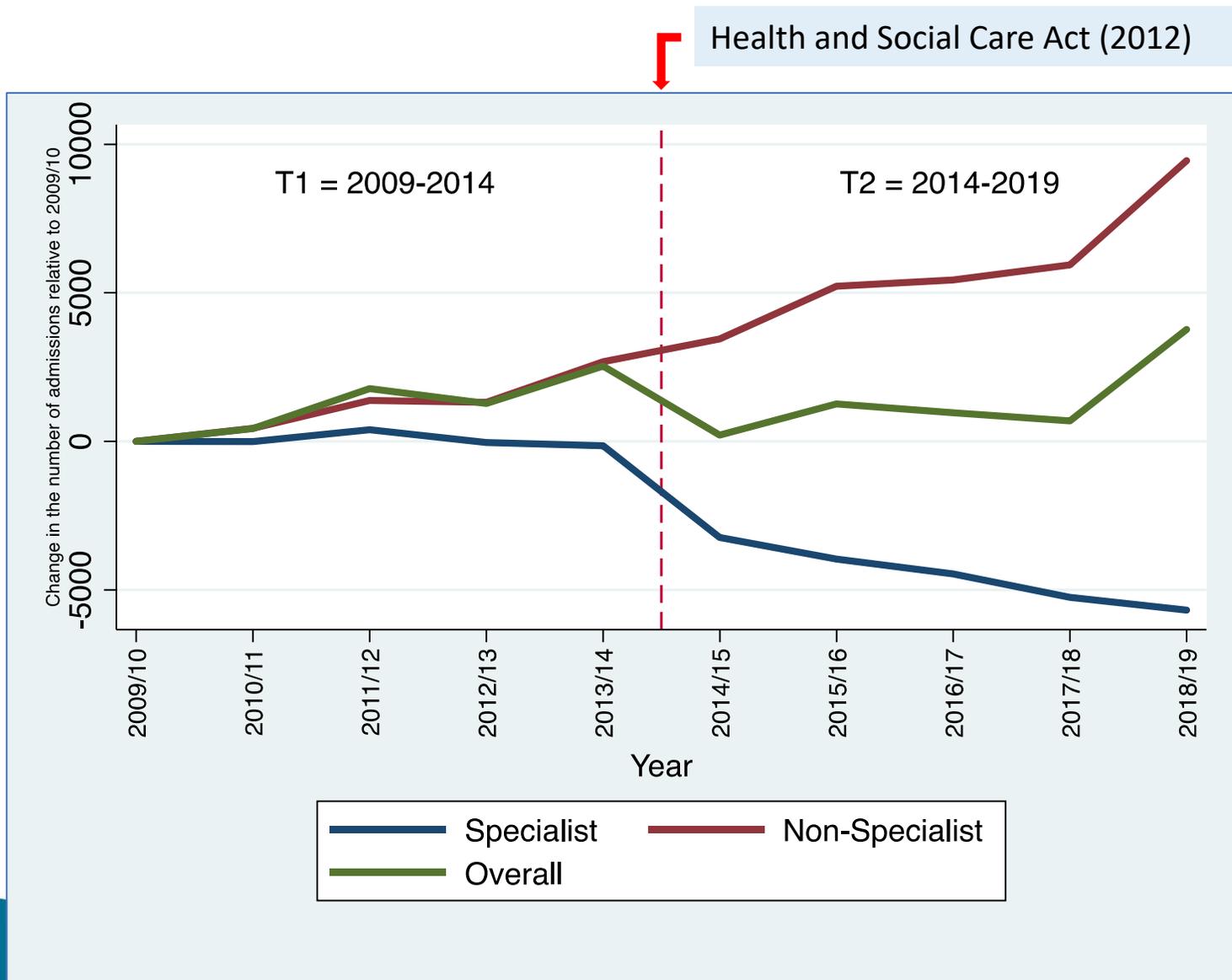 - Harmful drinking 38%
  - Dependence 42%

Annual changes in the number of alcohol withdrawal admissions by care setting relative to 2009/10 (Phillips et al, 2020)

Specialist admissions reduced by 45.5% between T1 & T2 (p=0.01)

Non-specialist admission increased by 43.8% between T1 & T2 (p=0.01)

Negative correlation (r= - 0.93, p=0.01) strong evidence of association

Alcohol Harm: Increasing priority

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- **NHS Plan - Prevention Programme:** Over the next five years, those hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs

- 10 million people drinking **hazardous levels**

- Alcohol costs the NHS £3.5bn per annum

- Currently, 1.26million alcohol-related hospital admissions

- Average age of death: alcohol-specific causes 54.3 years

(DH, 2013; Burton et al, 2016)

NHS

The NHS Long Term Plan

#NHSLongTermPlan
www.longtermplan.nhs.uk
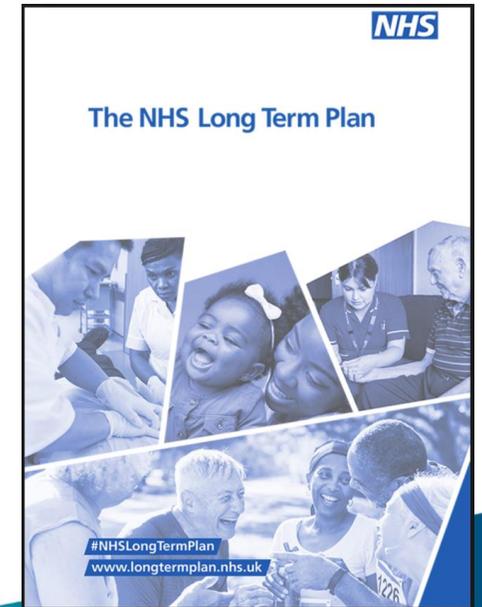
Alcohol Care Team

A multi-disciplinary ACT, 7 days/week based within Acute Hospital to provide packages of care that include:

- Screening and brief interventions
- carrying out comprehensive alcohol assessment
- specialist contribution to nursing and medical care planning
- management of medically-assisted alcohol withdrawal
- provision of psychosocial interventions
- planning safe discharge, including referral to community services
- clinical leadership by a senior clinician with dedicated time for the team
- provision of trust wide education and training in relation to alcohol.

(NHS, 2019)
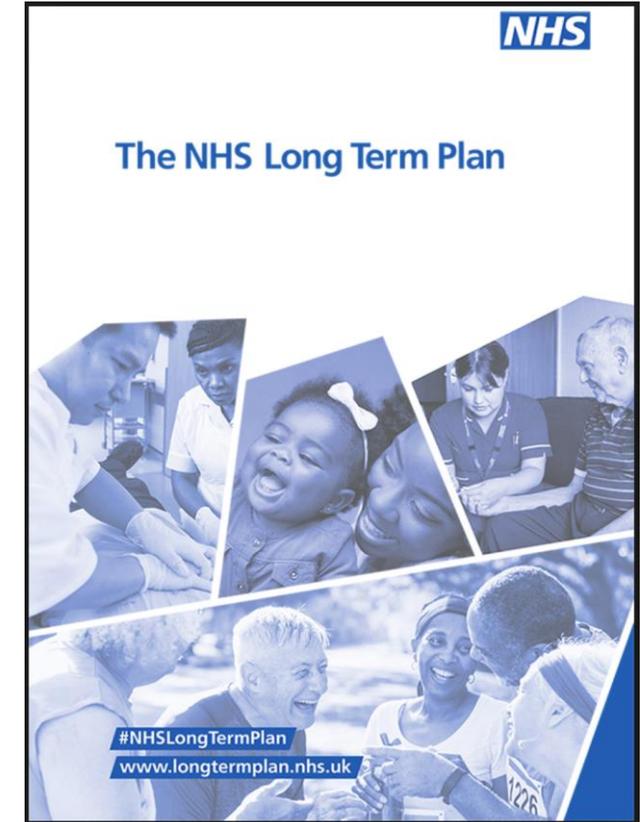
NICE CG 115

ALCOHOL-USE DISORDERS

THE NICE GUIDELINE ON DIAGNOSIS, ASSESSMENT AND MANAGEMENT OF HARMFUL DRINKING AND ALCOHOL DEPENDENCE

October 2014: The wording of the final bullet in recommendation 5.31.1.5 (and 8.3.4.5) has been corrected to make it clear that inpatient or residential assisted withdrawal should be considered for people who regularly drink between 15 and 30 units (not between 15 and 20 units) of alcohol per day, if they also have the additional complicating features mentioned in the recommendation.

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH
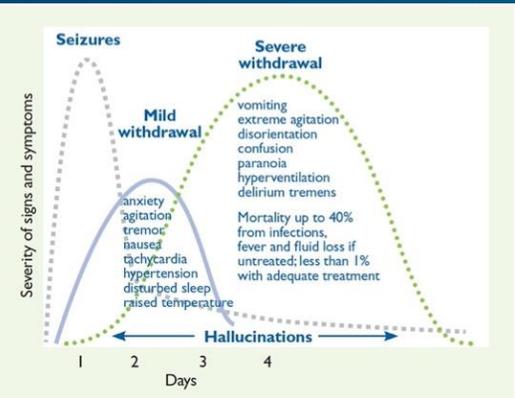
	Harmful Drinking	Alcohol Dependence		
		Moderate	Severe	Complex
	AUDIT 16-19	------------------ AUDIT 20 or more ------------------		
Initial assessment	✔	✔	✔	✔
Comprehensive assessment		✔	✔	✔
Psychological intervention	✔	✔	✔	✔
Care coordination	✔	✔	✔	✔
Community detox		✔		
Inpatient detox			✔	✔
Relapse medication		✔	✔	✔
Aftercare		✔	✔	✔
Case management			✔	✔
Res. rehab				
Prevent Wernicke's	✔	✔	✔	✔
Mutual aid	✔	✔	✔	✔
Families & carers	✔	✔	✔	✔

Setting	Specialist Inpatient (AW) N=2,682	Non-specialist Inpatient (AW) N=19,588	ACT (AUD inc. AW) N=141
Author	Eastwood et al (2018)	Phillips et al (2022)	Chambers et al (2021)
Data source:	NDTMS, 2014	HES-APC, 2017/18	Observational, 2016/17
Characteristics:			
Male	66.8%	73%	70.9%
Age (mean years)	47 yrs.	49.7 yrs.	50.8 yrs.
Black or minority ethnic group	11.7%	7.5%	5%
Housing	'Problem': 13.5%	'NFA': 2.3%	-
Alcohol consumption	80% DDD 16 units or more	-	Mean DDD 20 units
Clinical Comorbidity (mean):	-	Charlson Index: 4.1	HADS: 20.5
No previous alcohol treatment	45.6%	-	52.5%
Prior Community Tx. Engage.	57% (62 days)	-	18.4%
Admission:			
Planned/Elective Admission	100%	2.7%	-
Emergency Admission	-	97.3%	-
Inpatient Treatment Journey (Duration)	Treatment plan: 6 weeks (Inc. 1 week MAAW)	Median: 3 days (IQR 1-8)	Median: 7 days (IQR 4-19)
Outcomes:			
Engage: Follow Community Tx	61%	-	40%
Engage: Recovery Support	70%	-	43%
Readmission: 30-day	-	20.4%	-
Readmission: 6-months	-	52.0%	-
Planned Follow-Up:	57% of patients successfully completed treatment within 12 mths	-	46% of patients had improved drinking outcomes at 6 mths

Evaluating Alcohol Care Teams in England

NIHR | National Institute for Health and Care Research

Funding and Awards

Research Award

Programme of Research for Alcohol Care Teams: Impact, Value and Effectiveness (ProACTIVE)

Plain English Summary:

Alcohol causes over 60 different physical, and mental health conditions. In England, more people are being admitted to hospital and dying from alcohol-related disease than ever before. We know much [...] specialist addiction services, but much less is known about the 1 in 10 people admitted to acute hospitals who are also AD, but not necessarily seeking treatment. As patients may come into hospital for [...] missing opportunities to help empower them to make changes needed to improve their health. Alcohol Care Teams (ACT) have gradually developed in response to local need, but all in different ways. As [...]

Read more ⌄

Abstract:

Alcohol-related hospital admissions continue to rise, with estimates that 10% of patients admitted to acute hospitals may be alcohol dependent. Yet, there remains considerable variation in provision of [...] understanding their clinical effectiveness. The NHS long-term plan has invested to 'optimise' ACT through the development of existing services and the establishment of new teams in 25% of hospitals in [...] multi-disciplinary, integrated, mixed-methods study designed to evaluate the impact of ACT at macro (policy), meso (health system) and micro (patient) level. It will identify the 'optimal' models of ACT, d [...]

Read more ⌄

Chief Investigator(s):
Professor Julia Sinclair

Joint Lead Applicant:
Professor Thomas Phillips

Co-investigators:
Dr Amy O'Donnell, Dr Judith Cohen, Dr Krysia Canvin, Dr Nicola Kalk, Mr Colin Angus, Professor Colin Drummond, Professor Eileen Kaner, Professor Simon Coulton

Award:
£1,727,079.64

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Colin Angus – Sheffield
Simon Coulton – Kent
Amy O'Donnell – Newcastle
Nicky Kalk – SLaM NHS Trust
Eileen Kaner – Newcastle
Colin Drummond - KCL

ProACTIVE has four interconnected work packages (WP):

WP1. Defining Alcohol Care Teams

WP1a: **Comprehensive survey of national database of ACT provision in England**

WP1b: Define the range of components of care, and agree a **taxonomy for ACT interventions – Delphi study**

WP1c: Explore the reliability and linkage of nationally available data

WP2: Examining the impact of Alcohol Care Teams

WP2a: **quasi-experimental naturalistic effectiveness study** of three 'optimal' ACTs and three 'minimal'/no ACT sites, following-up patients for six months (using propensity score matching to identify a matched control group).

WP2b: Re-admission rates, length of stay etc will be assessed by an **interrupted time series analysis** using nationally available data.

WP2c: **cost-effectiveness of ACT at both meso and micro levels**.

WP3: A qualitative evaluation of ACTs, using an organisational ethnographic case study design enabling development of 4 case studies by triangulation of:

multiple data sources (documentary analysis, observation, interviews)

perspectives (decision-makers, clinical staff, patients

WP4: Data integration, dissemination and recommendations for future policy and practice using the 'Context and Implementation of Complex Interventions' framework, and co-production with stakeholders to generate guiding principles, and toolkit for best practice for ACTs

Conclusions

- Historic underinvestment in alcohol treatment
- Complex, high-need service users present to non-specialist settings often ill-equipped or resourced
- Competencies provide a template for clinical practice and the development of multidisciplinary ACTs
- Training and CPD for Alcohol Care Teams to be developed
- Health service and delivery research - impact and outcome of ACTs:
  - Effective training strategies for ACTs and Hospital Staff
  - Technology to support and guide withdrawal management
  - Transfer to ambulatory withdrawal programmes
  - Effective psychological interventions
  - Effectiveness of collaborative models of care

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