UNDER PRESSURE

Tackling two of the most common preventable health harms in the UK; high blood pressure and excessive alcohol consumption
About this report

This report sets out a series of recommendations to improve the management of hazardous, harmful and dependent drinking, especially in people with, or at risk of developing hypertension.

A number of experts were invited from across the clinical community in June 2014 to review the current management of alcohol misuse and hypertension across the UK and to devise a pragmatic way of moving forward to address the various hurdles that the group identified. Members of the group then took on the responsibility to make recommendations for each prioritised area. The group reconvened on March 12th 2015 to finalise the recommendations. It was decided that the expert group be named ‘Treat 15’, calling for 15% of dependent drinkers to receive treatment for alcohol misuse by 2015, based on figures showing that at present only around 6% of people receive it. 

Lundbeck Ltd initiated this report and provided funding support for the associated research and the Expert Group meetings, including honoraria for keynote speakers. Munro and Forster facilitated the group’s meetings, communications and provided secretariat services and editorial support, including support for the production and launch of this report, funded by Lundbeck Ltd, who reviewed the report for factual accuracy only before publication. However, editorial control of all materials rests with the authors. The views expressed in this report are those of the authors and may not necessarily reflect the views of Lundbeck Ltd.
Despite numerous public health initiatives, millions of people across the UK continue to risk their health and well-being by drinking harmful amounts of alcohol. During 2012, for instance, 14% of men and 9% of women in Great Britain drank on at least five days a week. On their heaviest drinking day, 29% of male drinkers and 21% of female drinkers consumed more than 8 and 6 units respectively. These numbers are estimates based on surveys, which notoriously underestimate true consumption by up to 70%.

The pervasive problem posed by heavy drinking imposes a considerable burden on the NHS. Alcohol is a leading risk factor for death and burden of disease for people in early adulthood until fifty years of age in the UK, as it is a cause of many acute and chronic diseases and injury, including cancers, cardiovascular diseases, neuropsychiatric disease, gastrointestinal diseases such as liver cirrhosis and pancreatitis, and both intentional and unintentional injury. This report focuses on a common, but in our experience less well-recognised and managed, co-morbidity between hypertension and alcohol abuse.

Hypertension is not only a disease, but is also another of the biggest risk factors for premature death and disability in England. It is estimated that hypertension affects more than 1-in-4 adults and that of every 10 people with high blood pressure (BP), 4 will be undiagnosed and 2 will be poorly controlled by their current treatment. This status quo is vital to address because, for people aged between 40–69 years old, every increase in systolic BP of 20 mm Hg (or 10 mm Hg diastolic BP) above normal is associated with at least a twofold difference in mortality from stroke, ischaemic heart disease and from other vascular causes.

Heavy use of alcohol and hypertension overlap considerably, and both can be recognised and treated at the primary health care level. This report discusses how primary care can deliver improved care for hypertension and hazardous and harmful use of alcohol by integrating screening, brief interventions, and treatment for both conditions, thus also reducing incidence of other cardiovascular diseases.

Professor Jürgen Rehm
September 2015
Toronto, Canada
While local authorities and CCGs (NHS Health Boards in Scotland, Local Health Boards [LHBs] and Area Planning Boards [APBs] in Wales, and the Local Commissioning Groups [LCGs] in Northern Ireland) are responsible for commissioning, several other stakeholders influence the development and delivery of local drug and alcohol services. For example, NHS England commissions primary care, armed services health care and offender health services in prisons. The voluntary sector can also act as important service providers, as well as being able to offer invaluable insights into local needs and barriers that hinder service delivery. As the Royal College of General Practitioners (RCGP) notes, this “represents an enormous change in commissioning, and ushers in a new era of localism.”

We believe that clinicians, commissioners and other stakeholders should seize the opportunity offered by the structural changes in the NHS to provide drug and alcohol services that promote a recovery based service on a thorough, detailed assessment of local needs and barriers that hinder service delivery. As the Royal College of General Practitioners (RCGP) notes, this “represents an enormous change in commissioning, and ushers in a new era of localism.”

An opportunity for involving primary care in the management of alcohol harm reduction

On the 1st April 2013, local authorities gained responsibility for commissioning public health services and the role of the National Treatment Agency for Substance Misuse was absorbed into Public Health England (PHE). Joint agreements between local authorities and Clinical Commissioning Groups (CCGs) should now form the foundation of alcohol harm-reduction services. These changes offer a new opportunity to involve primary care in providing integrated alcohol services that are tailored to meet local needs.

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We believe that clinicians, commissioners and other stakeholders should seize the opportunity offered by the structural changes in the NHS to provide drug and alcohol services that promote a recovery based service on a thorough, detailed assessment of local needs. Primary care services are the keystone of the improvements local authorities and CCGs (and equivalent bodies in the devolved nations) need to deliver to tackle the rising tide of alcohol-related disease.

In the future, payment by results (PbR) for substance abuse – introduced in the 2010 Drug Strategy – could add another layer of complexity to commissioning. Eight areas began piloting PbR in April 2012. Even if not mandatory, experience with the Quality and Outcomes Framework (QOF) suggests that PbR could produce a valuable revenue stream. In addition, the overlap between hypertension and alcohol use disorders helps general practitioners (GPs) meet QOF targets for cardiovascular disease. Identification and advice about alcohol abuse in the QOF targets for cardiovascular disease is currently subsumed under ‘lifestyle’ interventions. However, alcohol abuse is linked to a range of diseases and social consequences in a manner that other elements of the lifestyle advice for hypertension – such as salt – is not.

To achieve change there is a need to tackle entrenched, counterproductive behaviours and attitudes. A review of 28 studies concluded that health professionals generally held negative attitudes towards people that abused alcohol or illicit drugs. These negative attitudes reduced patients’ feelings of empowerment and undermined outcomes. Professional associations and commissioning bodies (CCGs, NHS Health Boards in Scotland, LHBs in Wales and LCGs in Northern Ireland) should consider education to counter these attitudes. Education could also focus on strengthening consultation skills, such as motivational interviewing, to improve what can sometime prove difficult discussions for doctors and patients. Insights into local issues – such as the association between socioeconomic deprivation and cardiovascular co-morbidities or a predilection for certain drinks - can also help inform education.

Alcohol abuse costs NHS England about £3.5 billion a year. The personal, social and economic cost of alcohol may be up to £55 billion a year in England and £7.5 billion in Scotland. However, each £1 spent on alcohol services saves an estimated £5 across health and the wider public services. Commissioners should develop funding mechanisms that address the issue of economic benefits.

Fundamentally, this report suggests that primary care should provide clinical and commissioning leadership for alcohol services in the community and more widely. Primary care providers and commissioners should develop and monitor effective care pathways between all parts of the treatment system from high street pharmacists, to the local surgery and community teams tackling substance abuse, to hospitals and the criminal justice system.
15% dependent drinkers to receive treatment for alcohol misuse by 2015.

Alcohol abuse costs NHS England about £3.5 billion a year. 

UNDER PRESSURE
About the Authors

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Our aim

“To ensure the adequate diagnosis of hypertension in primary care, and the early identification and appropriate intervention for hazardous, harmful and dependent drinking in this population as a first step to reducing risk factors for Noncommunicable diseases (NCDs). “

Summary of recommendations:

1. To raise awareness of alcohol as a risk factor for cardiovascular disease.

2. To ensure that the AUDIT-C assessment is routinely used as part of each review of hypertensive patients.

3. To increase the rate of brief interventions for people with hypertension and alcohol problems conducted in primary care.

4. To move to joint commissioning for a holistic and integrated alcohol treatment service that reflects the patient pathway from prevention through to specialist services.
   • To raise the profile of primary care within care pathway models, in order to encourage GPs to identify and better utilise resources already available within their primary healthcare team and across practices if appropriate.
   • To have clear and consistent points of access to a local alcohol care pathway, incorporating communication channels between GPs and specialist treatment providers and feedback on appropriate services for patients and follow-up information.
   • Commissioning bodies should have a nominated lead for alcohol commissioning who is actively involved in the performance monitoring and service quality improvement discussions at a local level.

5. To develop a national care pathway for alcohol that delineates service specification and clarifies the requirements and remits for clinical leads (providers) in every treatment system.
   • Devolved administrations should consider developing similar documents specifically addressing the association between hypertension and alcohol misuse.
   • Commissioners should develop funding mechanisms that address the issue of economic benefits.

6. To establish a network for clinical leads that provides regular networking events to share best practices and ideas, and works to develop relationships with existing networks (such as the Royal College of General Practitioners or national addiction psychiatry networks).
   • Encourage the Academic Health Science Networks to deliver supportive research and development collaborations within the area of alcohol and hypertension.

7. To develop a network of educators that can deliver training (such as use of AUDIT) to a wider audience of healthcare professionals, including practice nurses and community pharmacists.
OVERVIEW

High blood pressure and excessive alcohol consumption are both in the top five risk factors for burden of disease in Western Europe, and cause significant strain on NHS resources. In May 2013, the World Health Organization (WHO) adopted a 'Global Action Plan for Prevention and Control of Non-communicable Diseases (NCDs)' for the period 2013-2020. The targets pursued here include:

- 25% relative reduction in the risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases.
- At least 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context.
- 25% relative reduction in the prevalence or contain the prevalence of raised blood pressure, according to national circumstances.

In the primary care setting, there is significant overlap of alcohol use disorders and hypertension. European evidence suggests that 20.6% of hypertensive men aged 40–65 years have an alcohol use disorder (AUD) and 16.7% will have alcohol dependence. For women, it is estimated that 7.2% of hypertensive women aged 40–65 years old have an AUD and 5.8% have alcohol dependence. Conversely, it is conservatively estimated that patients with an AUD will have a 2–4 fold increased risk of hypertension.

Burden of alcohol misuse

Alcohol consumption per head in England has more than doubled between the mid-1950s and the late 2000s. Data from 2012 indicate that among adults who had drunk alcohol in the last week, 55% of men and 53% of women drank more than the recommended daily amounts, including 31% of men and 24% of women who drank more than twice the recommended amounts. Moreover, when weekly consumption was analysed, almost a quarter of men (24%) drank more than 21 units a week, including 5% who drank more than 50 units (a level considered to be higher risk). Among women, 18% usually drank more than 14 units a week, including 4% who drank more than 35 units.

Excessive alcohol use is estimated to account for approximately 10% of the UK burden of disease and death, as measured by Disability Adjusted Life Years (DALYs). By this measure, alcohol is one of the three biggest preventable health harms for disease and death in the UK, after smoking and obesity. Information on estimated cost to the NHS of alcohol misuse shows that it costs £3.5 billion every year, which is equal to £120 for every taxpayer. When considering trends over the last 10 years, health harms have grown considerably. PHE estimates that alcohol-attributable deaths in England rose from 14,406 in 2001 to 21,485 in 2012. Over the same period, alcohol-specific deaths, i.e. from conditions wholly caused by alcohol, rose by 30%.

The picture is similar in other parts of the UK. According to the 2008 Adult Drinking Patterns Survey, 72% of people in Northern Ireland drank alcohol. About 80% of those who consumed alcohol in the week before the survey exceeded the recommended daily limits. Moreover, 32% of respondents who had drunk in the previous week engaged in at least one binge drinking session. During 2013, 236 people died from alcohol-related causes in Northern Ireland.

In Wales, 27% of men and 18% of women drank on three or four days a week or more on average during the 12 months before the 2012 survey. About 1500 people die in Wales each year from alcohol-related causes, equivalent to 4.9% of all deaths.

Almost a fifth more alcohol is sold for each adult in Scotland than in England and Wales. Indeed, up to 50% of men and up to 30% of women in Scotland exceed the recommended daily guidelines. This contributed to Scotland having one of the fastest growing rates of liver disease and cirrhosis in the world.

Interventions for alcohol

There is a wealth of evidence supporting the efficacy of screening and brief interventions in reducing hazardous and harmful drinking. Current estimates are that 1.6 million people are believed to have some degree of alcohol dependence that does not require detoxification before treatment.

Brief advice, extended brief advice, psychological interventions and pharmacological treatment can be provided in three main settings: primary care, secondary care and specialist centres. Key barriers for service delivery include government inertia, localism, budget constraints, practitioner ambivalence and strength of the drinks industry. For effective change to be brought about, local Health and Wellbeing Boards will need to understand the far-reaching problems of excessive alcohol use.
Burden of hypertension

Recent data from PHE indicate that diseases caused by high blood pressure (BP) are estimated to cost the NHS over £2 billion every year. It is estimated that over 5 million people are unaware they have high BP yet it affects more than 1-in-4 adults and is another of the biggest risk factors for premature death and disability in England. Again, the picture is similar in other parts of the UK. In Northern Ireland, about 17% of adults have hypertension. In Wales, 20% of adults reported having high BP. The prevalence seems to be higher in Scotland: approximately 29% of adults had hypertension.

Of every 10 people with high BP, it is estimated that 4 are undiagnosed, 4 are on treatment and their BP is controlled and 2 are on treatment but their BP isn’t well controlled. Although the percentage of patients who achieve their BP goals has increased over the last decade (mainly due to better use of antihypertensive medications), the current evidence continues to indicate that the control of BP remains far from optimum.

For people aged between 40–69 years old, every increase in systolic BP of 20 mm Hg (or 10 mm Hg diastolic BP) above normal is associated with at least a twofold difference in mortality from stroke, ischaemic heart disease and from other vascular causes. Conversely, a decrease of 5 mm Hg diastolic BP has been estimated to result in a 34–40% reduced risk of stroke and a 21–25% reduced risk of coronary heart disease; and the risks reduce even further when diastolic BP is reduced by 7–10 mg Hg. PHE also estimates that, over 10 years an estimated 45,000 quality adjusted life years could be saved, and £850 million not spent on related health and social care, if England achieved a 5mmHg reduction in the average population systolic.

The prevalence of hypertension increases with age, from 11% in the 20–29 years age group to 72% in those more than 80 years old.

However, although adult guidelines recommend measuring BP at least every 5 years, 28 diagnosis levels (and implicitly, testing levels) are lowest among younger adults. Excessive alcohol consumption can often start at an early age, and is clearly associated with hypertension. Therefore, improving screening levels for hypertension in all age groups is an important step to early identification of both risk factors. The early treatment of younger patients is highlighted by the substantial lifetime burden associated with hypertension. Recent studies suggest that in a 30-year-old patient with hypertension, the lifetime risk for a cardiovascular event is 63.3%, compared with 46.1% in a person without hypertension, with an estimated loss of 5 years free of cardiovascular disease.

Alcohol as a major cause of secondary hypertension

Although the efficacy of antihypertensive drug therapy is well established, many patients do not reach their target BP. Key reasons for this failure, include poor patient compliance and persistence with treatment (excessive alcohol use may exacerbate poor compliance) and poor healthcare professional-recognition of secondary forms of hypertension (including heavy alcohol use). There is unequivocal evidence that heavy alcohol use is associated with poor cardiovascular outcomes, and recent studies now provide convincing evidence that reduction of alcohol consumption, even for light to moderate drinkers, is beneficial for cardiovascular health (including BP).

Systematic reviews of the literature (1997–2012) have found that heavy alcohol use is:

1. One of the most common causes of reversible hypertension.
2. Responsible for about one-third of all cases of nonischaemic dilated cardiomyopathy.
3. A frequent cause of atrial fibrillation.
4. Markedly increases risks of stroke (ischaemic and haemorrhagic).

Conversely, it is now well established that alcohol-induced hypertension resolves within 2 to 4 weeks of abstinence (or substantial reduction of intake). In one study, the proportion of alcohol dependent patients considered hypertensive on the basis of 24-hour BP criteria (daytime ≥ 135/85 mmHg) fell from 42% during alcohol drinking to 12% after 1 month of complete abstinence.

Analyses of several studies show that a reduction in alcohol consumption from more than 2 standard drinks per day reduces the BP of both hypertensive and normotensive people.

In addition, alcohol, along with non-adherence, is also one of the most common causes of treatment-resistant hypertension.
The role of primary care in the detection and treatment of hypertension and excessive alcohol use

We believe that healthcare professionals working in primary care are best placed to address both hypertension and AUD. Primary care is already central to the management of hypertension, with multiple opportunities to test and adjust treatment recommendations. Hypertension accounts for 12% of all GP visits in England, and considering the high prevalence of AUD and its significant impact on health, it is logical that similarly high numbers of patients presenting to primary care (for whatever reason) have an underlying AUD.

NICE guidelines for hypertension recommend offering behavioural action initially and then periodically for people undergoing assessment or treatment for hypertension.

“In this respect, reduction of heavy alcohol consumption is one of the proven effective measures to reduce hypertension.”

Likewise, NICE guidelines for alcohol use disorders recommend identification and treatment of alcohol problems with a focus on co-morbidities – including hypertension. The level of interventions increase with the level of drinking; however all but the most severe patients can be effectively managed in primary care.

Unfortunately, however, despite good evidence for alcohol interventions, less than 6% of people with alcohol dependence in England receive treatment, and systematic screening and intervention is still rare. At present, most people receiving treatment for alcohol have self-referred.

Several barriers to providing brief advice in primary care have been identified:

- Despite a robust evidence base, many GPs remain unconvinced that patients will take such advice to change their drinking behaviour.
- Practitioners are also concerned that they might offend patients by discussing alcohol or at least view alcohol as a ‘delicate’ subject to raise in the standard consultation. This is not supported by the evidence, which instead suggests that most people are not offended by being asked about their alcohol consumption and will give a reliable account if there is no sanction anticipated.
- Confusion about what advice they should actually be delivering on hazardous drinking.
- Lack of training or suitable intervention materials, though a variety of good quality training and materials is freely available.
- Inadequate financial incentives
- Unsupportive specialist alcohol service provision in terms of low capacity and long waiting lists
- Everyday time pressures

Another barrier to the identification of alcohol use disorders in people with hypertension is that, in the panel’s experience, there seems to be a general lack of awareness of the substantial increases in the relative risks of hypertension, stroke, and coronary heart disease associated with hazardous, harmful and dependent drinking. When a GP considers the cardiovascular risks of a patient, they will often use a risk calculator. However, none of the currently available calculators includes alcohol as a risk factor, and so it can easily be missed off the GP’s assessment.

Setting the management goals

Based on the evidence reviewed above it is logical that addressing both alcohol abuse and hypertension in a combined approach should contribute to the WHO goal of reducing the mortality burden of NCDs by 2025. We suggest that it is reasonable to set the following management goal:

“To ensure the adequate diagnosis of hypertension in primary care, and the early identification and appropriate intervention for hazardous, harmful and dependent drinking in this population as a first step to reducing risk factors for NCDs.”

Although there are several ways to work towards this goal, the authors prioritised 6 distinct areas for improvement:

1. Screening and diagnosis.
2. Interventions to deliver alcohol consumption reduction to lower BP.
5. Training and information.
6. Funding issues (to include commissioning).

In this report we describe each of these areas and provide pragmatic recommendations and guidance to help healthcare professionals improve the management of hazardous, harmful and dependent drinking in the hypertensive population.
Screening and diagnosis

The National Institute for Health and Care Excellence (NICE) guidelines for hypertension recommend offering behavioural action initially and then periodically for people undergoing assessment or treatment for hypertension. They further recommend that it is important to ascertain people’s alcohol consumption and encourage a reduced intake if they drink excessively as this can reduce BP and has broader health benefits. Likewise, guidelines for the prevention of harmful drinking recommend that alcohol screening should be performed as an integral part of practice, and should focus (when screening everyone is impractical) on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people with hypertension.

However, even in this ‘at risk’ population, screening for alcohol problems is only done on an intermittent basis, the results of the GP survey conducted as part of this report indicate that only about 1-in-5 people with hypertension are screened for harmful drinking. The GP survey was conducted online by medeConnect Healthcare Insight in January 2015. Members of the Doctors.net.uk community who are known to be GPs practicing in England were invited to participate, and the sample of 251 GPs who completed the survey was regionally representative.

The survey showed that of those patients with hypertension who are screened for harmful drinking, twice as many men were screened.

A typical GP will see 100 or more patients with hypertension every 3 months

**Base:** All respondents (251)

**Q1 -** How many patients have you seen with hypertension in the last 3 months?

- **Average:** 136 patients
- **Median:** 100 patients
Previous GP surveys have found that there is generally a low level of motivation within primary care to identify and address hazardous, harmful and dependent drinking, with lack of time and training cited as key barriers. The 3-item AUDIT-C, which takes little time to complete, is a recommended method for identifying hazardous and harmful consumption in primary care. A score of 5 or more (out of a maximum of 12) indicates the individual is possibly drinking at increasing risk (hazardous) or higher risk (harmful) levels, and that their drinking habits should be further evaluated using tools such as the full AUDIT. Training for conducting the AUDIT-C, AUDIT and other aspects of recognising and managing alcohol related problems is readily available to GPs and other primary healthcare professionals.

**OUR RECOMMENDATION IS:**
- To increase the use of AUDIT-C in patients undergoing assessment for or treatment of hypertension.

To achieve this goal, it is important to raise professional awareness of alcohol as a potential factor in the development of hypertension, and the use of the AUDIT-C as a pragmatic tool for screening. A first step will be taken at the 2015 annual scientific meeting of the British Hypertension Society, where this association will be given prominence (the first time at this meeting). We recommend that similar steps are taken to include alcohol on the agenda at other national congresses, for example at the annual conferences of the RCGP and the British Cardiovascular Society.

The identification of hazardous and harmful alcohol consumption is said to work best when it is incorporated into routine practices and systems. Many GP practices routinely use the QRISK2® calculator when assessing a patient for hypertension, however this does not include alcohol as a factor. We recommend to also incorporate tools that help identify alcohol use disorders into clinical practice. There are a number of web-based tools and smartphone apps already developed for this purpose.
Interventions to deliver alcohol consumption reduction to lower blood pressure

Despite good evidence for the effect of reducing alcohol on BP, the results of the survey conducted for this report showed that only half of GPs routinely highlight the link of hazardous, harmful and dependent drinking to raised BP to their patients with hypertension. Primary care studies show that providing brief advice can be effective in reducing hazardous or harmful drinking, and can be implemented during a routine appointment. Simple brief advice entails structured advice lasting 5-10 minutes, and visual tools are available to facilitate discussions with patients.

Almost all GPs are aware that heavy drinking affects blood pressure, however, they don’t always make their patients aware of this:

<table>
<thead>
<tr>
<th>Awareness of impact of excessive alcohol intake on blood pressure</th>
<th>% GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>92%</td>
</tr>
<tr>
<td>No</td>
<td>4%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are patients made aware of this?</th>
<th>% GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>50%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>46%</td>
</tr>
<tr>
<td>Never</td>
<td>4%</td>
</tr>
</tbody>
</table>

Base: All respondents (251)
Q7 - Are you aware of the impact of reducing excessive alcohol intake on lowering blood pressure?
Q8 - Do you make patients aware that reducing excessive alcohol intake is a way of reducing blood pressure?
Pathways to treatment

Although much work has been done to improve and integrate alcohol care pathways, the focus is generally on specialist services for people with more severe alcohol dependence. In our survey, just under two-thirds (62%) of GPs said they refer onwards at least some cases of hypertension and alcohol dependence – mostly to specialist services.

However, less attention is generally paid to people at the milder end of the spectrum. In particular, the point of access to treatment for people with low levels of dependence (or at the heavier end of hazardous or harmful drinking) can significantly change with the continual re-commissioning of alcohol services.

The frequency of these service changes can make it harder for the potential primary care referrers to know when and where to refer their patients who require more specialist interventions. 59% of GPs in our survey agreed that a clearly defined treatment pathway for people with hypertension and alcohol dependence would improve communication between primary and secondary care.

Furthermore, when a mild dependent drinker does come into first contact with an alcohol service, the environment can put them off returning for treatment. For example, they will often encounter illicit drug users or heavily dependent chaotic drinkers, and opening times of these clinics often clash with work and other commitments. This represents a real ‘missed opportunity’ to engage with the patient at an earlier stage of alcohol dependence.

Another, perhaps greater, missed opportunity is the early recognition and treatment of alcohol problems within primary care. It is estimated that people with alcohol dependence consult their GPs about twice as frequently as other patients in the same practice. This means that a GP is in a good position to notice co-morbidities (including hypertension) in patients whose alcohol risk levels are increasing. In the survey conducted for this report, 72% of GPs said they manage and treat at least some patients with hypertension and harmful drinking themselves or within their practice.

GPs nominated the availability of clearly defined treatment pathways as a key improvement for patients with both alcohol dependence and hypertension.

<table>
<thead>
<tr>
<th></th>
<th>% GPs</th>
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<tbody>
<tr>
<td>Clearly defined treatment pathway available</td>
<td>59%</td>
</tr>
<tr>
<td>Clearly defined shared care protocol available</td>
<td>54%</td>
</tr>
<tr>
<td>Improved education for general practice</td>
<td>16%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9%</td>
</tr>
</tbody>
</table>

Base: All respondents (251)

Q6 - How do you think treatment pathways and communication between primary and secondary care could be improved for those patients with both alcohol dependence and hypertension?

Q6a - Please rank these improvements from most to least useful.

"More communication from specialist sector re: how to deal with withdrawal symptoms"

"Study days and educational material"

"Improved discharge summaries and referral on to local services by secondary care"
OUR RECOMMENDATIONS ARE:

- To have a clear and consistent point of access to local alcohol treatment services.
- To raise the profile of primary care within local care pathway models, such that GPs are encouraged to identify and utilise resources already available within their practice and community. This could also include sharing of resources across several practices.
- To improve communication between the GP and service providers, including feedback on the suitability of the patient for the service and follow-up information.

Ways to facilitate these changes include the development of standardised referral and feedback templates based on the NICE guidelines that are already in existence. The development of a pragmatic model pathway that better demonstrates the steps that can be taken within primary care for people with hypertension and hazardous or harmful drinking or milder levels of alcohol dependence would also help. This pathway should be fully integrated to address the “triple fragmentation” between: primary care and specialists, clinical and mental health, health and social care and should take into consideration the important contributions that practice nurses and community pharmacists make by ensuring ‘every contact counts’. Devolved administrations should consider the most effective and efficient way to deliver these recommendations.
National clinical leadership

At present, community alcohol treatment services are commissioned by local authorities. Although CCGs may have a lead clinician for substance misuse and vulnerable groups, from a commissioning perspective there is no actual requirement to have one.

In general, clinical leads can be brought together through a number of national forums, Substance Misuse Management in General Practice (SMMGP), regional PHE sponsored and organised expert groups such as the one coordinated by the North of England. By contrast, in the panel’s experience, leadership in primary care/shared care is much less clear with several permutations for leadership appearing and a significant paucity of leadership embedded in primary care practices that serves as local system change ambassadors.

**OUR RECOMMENDATIONS ARE:**

- To develop a national care pathway (and equivalent in the devolved administrations) for alcohol that clarifies the requirements and remits for clinical leads (providers) in every treatment system.
- CCGs in England, NHS Health Boards in Scotland, LHBs and APBs in Wales, and LCGs in Northern Ireland to have a nominated lead for alcohol commissioning who is actively involved in the performance monitoring and service quality improvement discussions at a local level.
- Provider networks of practices should consider identifying local GP provider champions capable of operating at federated network level or the commissioning of a primary care/community organisation to service this on their behalf.
- To establish a network for clinical leads that provides regular networking events to share best practices and ideas, and works to develop relationships with existing networks e.g. RCGP SMAH, national addiction psychiatry networks, British Society of Gastroenterology (BSG). This network could also work to develop a national management training programme for clinical leads in substance misuse incorporating change management skills, budget and annual business planning, quality agenda requirements and safeguarding.
- Encourage the Academic Health Science Networks (AHSNs) to deliver supportive research and development collaborations within the area of alcohol and hypertension.
- Devolved administrations should consider the most effective and efficient way to deliver this recommendation.

Much work is needed to enable these changes, the first step is to get clarification from PHE and NHS England [and the equivalent bodies in the devolved administrations] regarding future plans for embedding clinical leadership into specifications and governance frameworks. All potential leadership initiatives should be developed in collaboration with organisations including (but not limited to) PHE, NHS England, RCGP SMAH, Royal College Psychiatry Faculty of Addiction Psychiatry and the equivalent bodies in the devolved administrations. A parallel approach is to conduct a national benchmarking audit to establish arrangements currently in place.

If a structured action plan could be designed and signed off with PHE and other key supporting agencies, a leadership development plan could be completed within 6 – 12 months.
Training and information

Although problems associated with hazardous, harmful and dependent drinking often make headline news, these stories tend to focus on the severe end of alcohol dependence, and public awareness of the association between hazardous, harmful and dependent drinking and heart disease is particularly low. In 2008, the Faculty of Public Health recommended that there be effective social marketing campaigns to change public attitudes to excessive alcohol consumption and to increase understanding of units consumed and awareness of alcohol related harm. In the panel’s view, this recommendation has not been adequately acted on, and increased public awareness remains a key unmet need.

In our survey, the vast majority (92%) of GPs said they were aware of the link between excessive alcohol intake and BP. More than half (57%) felt that more training is required to manage the link between alcohol intake and cardiovascular disease. A clear majority of GPs (75%) would welcome a clinical guideline on hypertension and alcohol misuse. At present, most doctors have only received a basic introduction to alcohol management in medical school and then variable amounts of post-graduate training, depending on specialty.

There is no formal requirement to include alcohol as part of GP specialty training.

Although the RCGP offers a range of excellent courses, including the RCGP certificate in the management of alcohol problems, training is harder for practice nurses, pharmacists and other members of the primary care team to access. There is also a general lack of alcohol training for doctors working in some secondary care specialties (e.g. cardiovascular medicine). Devolved administrations should consider the most effective and efficient way to deliver improved training and awareness among healthcare professionals and patients.

The current marketing strategy for PHE (2014–2017) already recognises the associations between hazardous, harmful and dependent drinking and heart disease. However, alcohol is given a relatively low priority (compared to smoking, diet and exercise etc.), due to factors such as budget cuts and the paucity of evidence of success in marketing-based interventions for those drinking above lower risk levels, who may require intensive face-to-face intervention and support to overcome their addiction. One of their stated goals is to “maintain and improve existing products that help people cut down including those under the Change4Life brand, Drink Line and the Department of Health’s Digital Challenge.”

We agree with this goal and recommend that a first step would be to include much more information about the ‘hidden’ health harms of hazardous, harmful and dependent drinking within all the materials produced. The current marketing strategy also notes there are too few active organisations (and too little money) within the public health community to fund big commercial campaigns, and that previous bespoke campaigns run with individual charities have not proven very successful. Our recommendation is to bring the various interested stakeholders together to fund a coordinated campaign to increase understanding of units consumed and awareness of alcohol related harm (including hypertension).

A first step in developing an efficient network of educators would be to produce a list of currently available training courses, identifying the people already delivering appropriate training. We recommend making contact with these experts and asking them to participate in a round table to discuss the set-up and implementation of such training courses. Devolved administrations should consider the most effective and efficient way to deliver this recommended within their local system.

OUR RECOMMENDATIONS ARE:

• To run a public awareness campaign to increase understanding of units consumed and awareness of alcohol-related harm (including hypertension).
• To develop a network of educators that can deliver training (e.g. use of AUDIT and AUDIT C) to a wider audience of healthcare professionals, including practice nurses and community pharmacists.
Funding issues

Since the 1st April 2013, the commissioning and funding of the bulk of alcohol services have been the responsibility of the 152 upper-tier, London borough and unitary local authorities in England.

In a 2014 survey conducted by Alcohol Concern, while most local authorities said they expected funding for alcohol services and activity to stay the same (39%) or increase (43%) over the next three years, the service providers surveyed told a different story; with 30% already reporting a reduction in spending and 61% saying that they expected a decrease in funding. 76

Indeed, treatment providers reported a significant discrepancy between the greater prioritisation of alcohol as a health issue, and the actual funding received to deliver alcohol services. 76 This situation may be further exacerbated by the expected removal of the public health budget ring-fencing in 2016/7.

In our survey, a majority (65%) of GPs felt that expenditure on local alcohol services is already insufficient. 84

The lead responsibility for commissioning drug and alcohol services currently rests with local authorities. 77 CCGs may assume some wider responsibilities for commissioning if the local authority delegates these to them. In the Alcohol Concern 2014 survey, two-thirds of CCGs were not currently directly funding any alcohol services or activity. 76

**OUR KEY RECOMMENDATION IS:**
- To move to joint ‘whole-system’ commissioning for a holistic and integrated alcohol treatment service that reflects the patient pathway from prevention through to specialist services.

There needs to be a funding strategy that takes into account the work that can be performed within primary care. Primary care is commissioned directly by NHS England, and very few CCGs have taken on delegated responsibility for alcohol services. However, in the panel’s opinion, CCGs generally have a better infrastructure (e.g. medicines management) and operational capacity than local authorities to tackle alcohol abuse. For this to happen, commissioners will need to better understand that providing a good clinical alcohol service that provides earlier intervention will ultimately save money, for example by reducing the financial burden of alcohol-related hospitalisation.

We recommend that a service specification that clearly defines roles, responsibilities and standards is developed to guide co-commissioning of a holistic service that meets the needs of the locality. In parallel, it is vital to engage with and mobilise leaders in PHE and NHS England to support this move.

---

The majority of GPs feel there is not enough expenditure on alcohol services currently in England

![Expenditure on alcohol services % GPs](chart)

**Base:** All respondents (251)

**Q12 - Is the expenditure on alcohol services in your area...**

- Not enough: 65%
- About right: 34%
- Too much: 1%
Devolved administrations

Although the expert group of participants did not specifically look to include representatives from all four nations, the group acknowledged it was important to look at Scotland, Wales and Northern Ireland.

Devolved administrations should consider the most effective and efficient way to commission services that encourage the assessment of hypertension in people with AUD and vice versa within the context of their strategic alcohol policies. In Northern Ireland, for example, phase 2 of the New Strategic Direction for Alcohol and Drugs (NSD)\(^7\) includes five ‘pillars’ that provide the programme’s "conceptual and practical base":

- Prevention and early intervention.
- Treatment and support.
- Law and criminal justice.
- Monitoring, evaluation and research.
- Harm reduction.

Harm reduction, according to the NSD, “refers to policies, strategies and programmes designed to reduce the harmful consequences of substance misuse”. The report focuses on substance abuse per se. However, the evidence in this report suggests that harm reduction policies, strategies and programmes should encompass co-morbidities, such as hypertension.\(^7\)

Moreover, the NSD set an objective of increasing “awareness, information, knowledge, and skills on all aspects of alcohol and drug-related harm in all settings and for all age groups”.\(^7\) We believe that this should encompass awareness and active management of secondary hypertension.

The main approach taken by Public Health Wales (PHW) is to deliver alcohol brief intervention training.\(^7\) However, PHW also developed a Smart Phone App called ‘1Drink 1Click’, which provides feedback and health advice tailored to the user. In addition, since October 2011 PHW has collaborated in a Knowledge Transfer Partnership with Cardiff University’s Violence Research Group to implement an alcohol brief intervention programme across primary and secondary care in order to reduce the overall burden of alcohol misuse on the NHS and Social Services. We believe that awareness and active management of secondary hypertension should be central to such innovations.

NHS Scotland also recognises the need for greater effort on prevention, in particular delivering screening and brief interventions as part of the routine services.\(^8\) NHS Health Boards should commission services that meet local need, which given the high prevalence of cardiovascular disease should encompass hypertension. Therefore, local Alcohol and Drug Partnerships (ADPs) should consider local need as a whole, including health inequalities and co-morbidities, when determining the structure of alcohol services in each NHS Health Board.
Conclusion

There is no single answer to the problems posed by alcohol abuse or hypertension, which are both in the top five risk factors for burden of disease in Western Europe. Tackling these common diseases individually requires a co-orientated response that includes legislation (e.g. alcohol pricing and food standard), patient and public education and active surveillance and management by healthcare professionals in the community and secondary care. However, raised BP and AUD are common co-morbidities both through co-incidence and because alcohol abuse can cause secondary hypertension. Therefore, screening for and managing hypertension in people with AUD and vice versa is a clinical imperative.

The conjunction of several mutually reinforcing factors means that community health services and social care now has an unprecedented opportunity to tackle alcohol abuse and, therefore, secondary hypertension. As this report outlines, GPs can offer an expanding growing armamentarium of effective evidence-based interventions and the reorganisation and devolution of the health services provides opportunity for commissioning co-ordinated services that are responsive to both local needs and socio-economic circumstances.

We believe that clinicians and commissioners across the UK need to grasp this opportunity to improve detection and management of hypertension and AUD to help alleviate the morbidity, mortality, and societal problems arising from these intimately associated conditions. But we need to act fast: clinical and commissioning inertia and pressure from competing priorities could soon close this unprecedented window of opportunity.
UNDER PRESSURE
Biographies of Authors

Jackie Ballard
Jackie Ballard has been the Chief Exec at Alcohol Concern – the charity campaigning for a change in our drinking culture - since July 2014. Prior to this, she had a varied career which has encompassed social work, further education lecturing, training, a 4 year stint as an MP and, more recently, CEO roles at the RSPCA, Action on Hearing Loss and Womankind Worldwide. She is on the Board of Newlon Housing Association and is chair of the Outward charity.

Adrian Brown
Adrian is the alcohol and drug nurse specialist within the Liaison Psychiatry team at Northwick Park Hospital, London, where he works in close conjunction with the acute assessment unit (admissions) and the gastro-hepatology teams. Much of his work involves patients who are dependent on alcohol or at the high end of hazardous/harmful drinking levels.

Prof. Oscar D’Agnone
Professor Oscar D’Agnone has over twenty five years of experience in helping patients with addiction issues. He is a Consultant Psychiatrist and Medical Director. Prof D’Agnone supervises more than 2,500 detoxifications per year whilst working for a number of clinical and rehabilitation units. He is Medical Director for CRI (Crime Reduction Initiatives), which is the largest addictions organisation in the UK. He has authored the latest standard text books and guidelines on addiction, advises governments, whilst also maintaining a high level of clinical interactivity with his patients.

Dr. Carsten Grimm
Dr. Grimm has been trained in General Practice and Addiction Medicine. He has been the Clinical Lead for the alcohol treatment services in Kirklees before moving into commissioning and research, currently working as a board member for Bradford Districts CCG. He is a member of the Medical Council on Alcohol, the Society for the Study of Addiction and Clinical lead for the RCGP alcohol certificate.

Brian Gunson
Brian Gunson is a biochemistry graduate and has thirty years’ experience in health care including the pharmaceutical industry, the NHS, medical charities and consultancy. He joined Munro and Forster Communications in 1990 and has been Chairman since 2002. From 1996 to 2003, Brian was a trustee of the Patients Association, and took on the roles of Vice Chairman and Acting Chairman. In 1999 he was appointed lay member of a Primary Care Group and in 2001 became a non-executive director of a Primary Care Trust. He is a Member of the Chartered Institute of Public Relations, a Forum Member of the Royal Society of Medicine, a panel member on NHS England’s Hepatobiliary and Pancreas CRG and the SHCA through his role as a trustee of the British Liver Trust. He is a Director of Hertfordshire Healthwatch and a lay Board member of Herts Valley CCG.

Dr. Linda Harris
Dr. Linda Harris FRCGP is Chief Executive of Spectrum Community Health, one of the UK’s first NHS ‘spin out’ social enterprises delivering Substance Misuse and Community Wellbeing, Health and Justice and Contraception and Sexual Health. Locally, Dr. Harris is a member of the Wakefield Integration Executive which includes the Chief Executives of the local health and social care economy. The programme includes initiatives and pathways to support a reduction in unnecessary hospital bed stays and reduced A and E admissions. The Wakefield Alcohol Hospital Liaison pathway is one such example. Since 2005, Dr. Harris has been the Medical Director of RCGP Substance Misuse Associated Health (SMAH) which offers a range of specialist education and training to primary care professionals in substance misuse and holds a national role as Chair of the NHS England Clinical Reference Group for Health and Justice. Dr. Harris has been involved in the development of a number of national policy and guidance documents notably the, Patel Review of Substance Misuse Services in Prisons, NICE Guidelines for the Management of Hazardous and Harmful Drinking (NICE 115) the National UK Clinical Guidelines for the Management of Substance Misuse.

Mark Holmes
Mark Holmes BSc, RMN, SPMH has worked within the alcohol misuse field for nearly two decades developing services in community treatment, hospital alcohol liaison, IBA, alcohol related long term conditions and end of life care. He has been an advisor to the Department of Health on IBA and improving end life care in liver disease. Mark was awarded the Nursing Times Mental Health Nurse of the Year in 2012 for his work on preventing alcohol related hospital admissions by increasing levels of care. Publications include those highlighting the need for greater professional and public awareness of the impact of alcohol on the cardiovascular system.

Dr. Francis Keaney
Dr. Francis Keaney is a Consultant Addiction Psychiatrist at South London and Maudsley Foundation Trust’s (SLaM) acute assessment unit, Maudsley hospital and the Beresford project in Greenwich.
Prof. Tom MacDonald
Prof. MacDonald is Professor of Clinical Pharmacology & Pharmacoepidemiology at University of Dundee. He is the Director of the Medicines Monitoring Unit & Hypertension Research Centre as well as an Honorary Physician. He is currently President of the British Hypertension Society.

Dr. Zulfiquar Mirza
Dr. Zulfiquar Mirza is a Consultant in Emergency Medicine at West Middlesex University Hospital. He is the Past President of the Emergency Medicine section at the Royal Society of Medicine. His specialist areas of interests include alcohol and drugs of abuse. He has many peer reviewed publications and book chapters. He has given lectures nationally and internationally. He is the co-lead on alcohol at the Royal College of Emergency Medicine. He has spoken on BBC News, ITV, Sky News and Channel 5 News as well as on Radio including Radio 4 and Radio 5 Live.

He is the lead and Chair of the Trauma Board of WMUH.

Prof. Rehm is Director of the Social and Epidemiological Research Department at the Centre for Addiction and Mental Health and is Professor and Chair of Addiction Policy at the University of Toronto. He is also Head of the Epidemiological Research Unit, Clinical Psychology and Psychotherapy, Dresden University of Technology, Dresden, Germany.

Dr. Paul Richardson
Dr. Richardson qualified from the University of Newcastle upon Tyne in 1990. He has since worked in 3 of the UK’s 7 designated liver transplant units. He was a clinical research fellow at the King’s College Hospital Liver Unit and the University of Minnesota. Prior to his appointment at Royal Liverpool University Hospital in March 2009 he was a consultant hepatologist at Luton and Dunstable NHS trust with an honorary contract at Addenbook’s NHS Trust Liver Unit Cambridge for 3 years. He is now the clinical director of the gastroenterology and hepatology department at the Royal and the Trust’s Clinical Alcohol Lead. Dr. Richardson’s key area of interest is the management of patients with chronic liver disease with particular relevance to patients with complications secondary to cirrhosis. His endoscopic interests centre around the management of portal hypertension. Dr. Richardson is also the Hepatology Lead for the North West Coast Clinical Research Network.

Prof. Gabriel Scally
Prof. Scally completed specialist training in public health in N Ireland (including academic post) and occupied senior public health posts there before becoming a Regional Director of Public Health in England. He worked for the Regional and Strategic Health Authorities as well as the Department of Health, as well as being a visiting professor at the University of Bristol and the University of West England.

Biographies of Expert Group Participants

Ben Lumley
Ben Lumley is the Blood Pressure Programme Lead at Public Health England. Public Health England works to protect and improve the nation’s health. It has convened the Blood Pressure System Leadership Board to improve the prevention, detection and management of high blood pressure in partnership across local and national government, the health system, voluntary sector and academia.

Biographies of Observers

Iain Armstrong
Iain Armstrong has 20 years’ experience in alcohol policy with Alcohol Concern, Department of Health and now Public Health England. PHE was set up in 2013 to protect and improve the nation’s health and to address inequalities. Iain is part of the PHE national team leading on reducing alcohol harm, providing technical advice on effective planning, quality improvement in interventions and leading PHE’s national work around alcohol services in hospitals.

Dr Mark Prunty
Senior Medical Officer, Drug and Alcohol Policy, Department of Health

Dr Prunty is Senior Medical Officer for Drug and Alcohol Policy, Department of Health (England) and a practising addiction psychiatrist (Surrey and Borders Partnership NHS Foundation Trust).
Appendix
AUDIT

This is one unit of alcohol...

<table>
<thead>
<tr>
<th>Unit of Alcohol</th>
<th>Scoring System</th>
</tr>
</thead>
<tbody>
<tr>
<td>A pint of regular beer larger or cider</td>
<td>0, 1</td>
</tr>
<tr>
<td>A pint of premium beer larger or cider</td>
<td>2</td>
</tr>
<tr>
<td>A single glass of wine</td>
<td>3</td>
</tr>
<tr>
<td>A single measure of spirits</td>
<td>4</td>
</tr>
<tr>
<td>A glass of sherry</td>
<td>0</td>
</tr>
<tr>
<td>A single measure of apéritif</td>
<td>1</td>
</tr>
</tbody>
</table>

...and each of these is more than one unit

<table>
<thead>
<tr>
<th>Unit of Alcohol</th>
<th>Scoring System</th>
</tr>
</thead>
<tbody>
<tr>
<td>A pint of regular beer larger or cider</td>
<td>2</td>
</tr>
<tr>
<td>A pint of premium beer larger or cider</td>
<td>3</td>
</tr>
<tr>
<td>Alcopop or can/bottle</td>
<td>1.5</td>
</tr>
<tr>
<td>Can of premium larger or strong beer</td>
<td>2</td>
</tr>
<tr>
<td>Can of super strength larger</td>
<td>4</td>
</tr>
<tr>
<td>Glass of wine 175ml</td>
<td>2</td>
</tr>
<tr>
<td>Bottle of wine</td>
<td>9</td>
</tr>
</tbody>
</table>

Audit

<table>
<thead>
<tr>
<th>Question</th>
<th>Scoring System</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?</td>
<td>Never, Monthly, 2 - 4 times per month, 2 - 3 times per week, 4+ times per week</td>
</tr>
<tr>
<td>HOW MANY UNITS OF ALCOHOL DO YOU DRINK ON A TYPICAL DAY WHEN YOU ARE DRINKING?</td>
<td>1 - 2, 3 - 4, 5 - 6, 7 - 9, 10+</td>
</tr>
<tr>
<td>HOW OFTEN HAVE YOU HAD 6 OR MORE UNITS IF FEMALE, OR 8 OR MORE IF MALE, ON A SINGLE OCCASION IN THE LAST YEAR?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU FOUND THAT YOU WERE NOT ABLE TO STOP DRINKING ONCE YOU HAD STARTED?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU FAILED TO DO WHAT WAS NORMALLY EXPECTED FROM YOU BECAUSE OF YOUR DRINKING?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU NEEDED AN ALCOHOLIC DRINK IN THE MORNING TO GET YOURSELF GOING AFTER A HEAVY DRINKING SESSION?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU HAD A FEELING OF GUILT OR REMORSE AFTER DRINKING?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU BEEN UNABLE TO REMEMBER WHAT HAPPENED THE NIGHT BEFORE BECAUSE YOU HAD BEEN DRINKING?</td>
<td>Never, Less than monthly, Monthly, Weekly, Daily or almost daily</td>
</tr>
</tbody>
</table>
### Audit

<table>
<thead>
<tr>
<th>Scoring system</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>HAVE YOU OR SOMEBODY ELSE BEEN INJURED AS A RESULT OF YOUR DRINKING?</td>
<td>No</td>
</tr>
<tr>
<td>HAS A RELATIVE OR FRIEND, DOCTOR OR OTHER HEALTH WORKER BEEN CONCERNED ABOUT YOUR DRINKING OR SUGGESTED THAT YOU CUT DOWN?</td>
<td>No</td>
</tr>
</tbody>
</table>

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence
Appendix
AUDIT-C

This is one unit of alcohol...

...and each of these is more than one unit

<table>
<thead>
<tr>
<th>Alcohol Type</th>
<th>Scoring System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half a pint of regular beer larger or cider</td>
<td>1 small glass of wine</td>
</tr>
</tbody>
</table>

Audit

<table>
<thead>
<tr>
<th>HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?</th>
<th>Scoring System</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Never</strong></td>
<td><strong>Monthly</strong> or less</td>
<td><strong>2 - 4 times per month</strong></td>
</tr>
<tr>
<td><strong>1 - 2</strong></td>
<td><strong>3 - 4</strong></td>
<td><strong>5 - 6</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW MANY UNITS OF ALCOHOL DO YOU DRINK ON A TYPICAL DAY WHEN YOU ARE DRINKING?</th>
<th>Scoring System</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Never</strong></td>
<td><strong>Less than monthly</strong></td>
<td><strong>Monthly</strong></td>
</tr>
<tr>
<td><strong>1 - 2</strong></td>
<td><strong>3 - 4</strong></td>
<td><strong>5 - 6</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW OFTEN HAVE YOU HAD 6 OR MORE UNITS IF FEMALE, OR 8 OR MORE IF MALE, ON A SINGLE OCCASION IN THE LAST YEAR?</th>
<th>Scoring System</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Never</strong></td>
<td><strong>Less than monthly</strong></td>
<td><strong>Monthly</strong></td>
</tr>
<tr>
<td><strong>1 - 2</strong></td>
<td><strong>3 - 4</strong></td>
<td><strong>5 - 6</strong></td>
</tr>
</tbody>
</table>

Scoring: A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive.
### Appendix

**Remaining AUDIT questions**

<table>
<thead>
<tr>
<th>Audit</th>
<th>Scoring system</th>
<th>Your Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU FOUND THAT YOU WERE NOT</td>
<td>0  1  2  3  4</td>
<td></td>
</tr>
<tr>
<td>ABLE TO STOP DRINKING ONCE YOU HAD STARTED?</td>
<td>Never  Less than monthly  Monthly  Weekly  Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU FAILED TO DO WHAT WAS</td>
<td>0  1  2  3  4</td>
<td></td>
</tr>
<tr>
<td>NORMALLY EXPECTED FROM YOU BECAUSE OF YOUR DRINKING?</td>
<td>Never  Less than monthly  Monthly  Weekly  Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU NEEDED AN ALCOHOLIC DRINK</td>
<td>0  1  2  3  4</td>
<td></td>
</tr>
<tr>
<td>IN THE MORNING TO GET YOURSELF GOING AFTER A HEAVY DRINKING SESSION?</td>
<td>Never  Less than monthly  Monthly  Weekly  Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU HAD A FEELING OF GUILT OR</td>
<td>0  1  2  3  4</td>
<td></td>
</tr>
<tr>
<td>REMORSE AFTER DRINKING?</td>
<td>Never  Less than monthly  Monthly  Weekly  Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>HOW OFTEN DURING THE LAST YEAR HAVE YOU BEEN UNABLE TO REMEMBER</td>
<td>0  1  2  3  4</td>
<td></td>
</tr>
<tr>
<td>WHAT HAPPENED THE NIGHT BEFORE BECAUSE YOU HAD BEEN DRINKING?</td>
<td>Never  Less than monthly  Monthly  Weekly  Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>HAVE YOU OR SOMEBODY ELSE BEEN INJURED AS A RESULT OF YOUR DRINKING?</td>
<td>0  1  2  3  4</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
</tr>
<tr>
<td>HAS A RELATIVE OR FRIEND, DOCTOR OR OTHER HEALTH WORKER BEEN</td>
<td>0  1  2  3  4</td>
<td></td>
</tr>
<tr>
<td>CONCERNED ABOUT YOUR DRINKING OR SUGGESTED THAT YOU CUT DOWN?</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

**TOTAL Score equals**

AUDIT C Score (above) + Score of remaining questions
### Alcohol Misuse
The term alcohol misuse is a working definition taken from NICE guideline 115 on alcohol dependence and is not used as a diagnostic term or to imply intentionality.

### Alcohol-Related Harm
Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as ‘alcohol specific’. If it is only partly caused by alcohol it is described as ‘alcohol attributable’.

### Alcohol-Use Disorder
Alcohol-use disorders cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence.

### Dependence
A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations.

### Brief Intervention
This can comprise either a short session of structured brief advice or a longer, more motivationally based session (that is, an extended brief intervention – see also below). Both aim to help someone reduce their alcohol consumption or abstain, and can be carried out by non-alcohol specialists.

### Extended Brief Intervention
This is motivationally based and can take the form of motivational-enhancement therapy or motivational interviewing. The aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change. In this guidance, all motivationally based interventions are referred to as ‘extended brief interventions’.

### Harmful Drinking
Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis.

### Hazardous Drinking
A pattern of alcohol consumption that increases someone’s risk of harm. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. The term is currently used by WHO to describe this pattern of alcohol consumption. It is not a diagnostic term.

### Screening
Screening is used to define the initial process of identifying people who are not seeking treatment for alcohol problems but who may be a hazardous or harmful drinker, or who have alcohol dependence.

### Whole-System Commissioning
The commissioning guide uses a whole-system approach to the commissioning of alcohol services. A whole-system approach, advocated in the Drug Strategy 2010, explores the issue of alcohol misuse in a defined population, across the whole spectrum of identification, treatment and aftercare. It brings partners together to make integrated commissioning decisions, to pool investment and share risk. The aim of a whole-system approach is to commission services that ensure the targeted population can access well integrated, high-quality and clinically effective alcohol services.
Lundbeck Ltd initiated this report and provided funding support for the associated research and the Expert Group meetings, including honoraria for keynote speakers.

Munro and Forster facilitated the group’s meetings, communications and provided secretariat services and editorial support, including support for the production and launch of this report, funded by Lundbeck Ltd, who reviewed the report for factual accuracy only before publication.

However, editorial control of all materials rests with the authors. The views expressed in this report are those of the authors and may not necessarily reflect the views of Lundbeck Ltd.