



Alcohol Treatment Systems and Services

Position Paper

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Foreword	4
Acknowledgements.....	6
Introduction	7
Policy Context.....	8
Service Provision.....	11
Consultations	13
Public Health.....	15
Definitional Issues.....	16
Alcohol Problems	17
Treatment.....	19
Alcohol Problems Continuum	19
Treatment Effectiveness	20
Screening.....	21
Assessment.....	21
Brief Interventions	21
Brief Treatments	22
Specialist Treatment	22
Treatment Systems and Services – Best Practice	24
The Four Tier Model for the Provision of Treatment and Interventions.....	24
Tier One Interventions	25
Tier Two Interventions	25
Tier Three Interventions	25
Tier Four Interventions.....	26
Integrated Care Pathways.....	26
Towards Quality and Fairness.....	27
Conclusion.....	28
Recommendations	30
Bibliography	32
Appendix I European Charter on Alcohol	36
Appendix II European Action Plan	39
Appendix III Strategic Task Force on Alcohol Report 2004	41
Appendix IV Advisory Group.....	43

Foreword

“Are we content to allow the majority of people with drinking problems to remain unrecognised, and unhelped, or do we wish to encourage more active intervention?” (Shaw et al., 1978)

This question could have been asked 20 years ago of heart disease or cancer. Due to the frequency and impact of these two conditions within the population, health policy makers and planners with all the health intelligence available put in place national strategies and dedicated resources to assist in the early identification of these two conditions and provided greater emphasis on access to treatment services. The results are such that there is now an awareness within the population of prevention factors and early intervention. Undoubtedly work needs to continue to reduce current rates of mortality.

Alcohol problems are rated third following heart disease and cancer as the most serious contributor to mortality and morbidity by the World Health Organisation. In Ireland between 1995 and 2004 alcohol related deaths doubled to 1,775 and 50% of alcohol related deaths occurred to people 50 to 70 years of age. (HRB 2007) These figures are seen as an underestimate of the mortality rates. This means that a large proportion of these people died without the knowledge or support of knowing that they could have received help for their alcohol problems throughout their lives. Their families are left to grieve the premature loss of a relative but also the loss of a life that in many cases had not reached its true potential due to gradual alcohol impairment or disability. These losses are unacceptable.

What are the personal and human consequences of this data on human lives? We know that people harmed by years of heavy alcohol use are fathers, mothers, brothers and sisters, friends and colleagues. Physical illness is a huge cost to their livelihood and that of their families in terms of lost productivity and in particular the loss of a once former responsible and active family member who once cared for the well-being of their families. Physical illness from heavy drinking is a feature of an advanced alcohol problem. Prior to the onset of physical illness, there are gradual changes in mood, behaviour and personality which carry a significant burden for those living or working with such a person. This psychological burden and distress falls heaviest on families and children who do not feel they have any choice but to put up with these very difficult behaviours. The HRB cannot count this distress in figures or percentage terms. Neither do people feel they can liberally speak out due to the stigma and shame and confusion caused by harmful drinking or third party effects. And so there is a silence of deep suffering and pain.

This paper calls for a comprehensive treatment strategy with fully resourced systems and services in order to arrest premature death and reduce the impact of alcohol-related harm throughout Irish society. For a country with the highest levels of alcohol related harm in Europe and one of the highest levels of per capita consumption, we need to offer a humanitarian response by offering hope and help to the many who are suffering and will suffer alcohol related health and social consequences in years to come.

The reality of not acting now will have far reaching consequences for the quality of life in Ireland for years to come. Alcohol Action Ireland will continue to advocate for this as a priority issue.

“All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.”

EU Charter on Alcohol 1995

Marion Rackard
Executive Director

Alcohol Action Ireland
November 2007

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Introduction

Alcohol Action Ireland is a non-governmental organisation that was founded in 2003. The objective of AAI is to increase understanding of inappropriate use of alcohol on the health and well being of Irish society and the public policies necessary to reduce the problems associated with such use. Through advocacy, we aim for the implementation of policies necessary to reduce the problems which will protect people from future harm from alcohol and which supports those currently enduring such harm.

With regard to treatment, AAI draws on the principles of equity, accountability, quality and people centredness, which underpin the Health Strategy: Quality and Fairness; A Health System for You. (Department of Health, 2001) AAI is also guided by the ethical principles and goals of the European Charter on Alcohol, which states "That all people with hazardous and harmful alcohol consumption and members of their families have the right to accessible treatment and care". (World Health Organisation Europe, 1995)

The position of AAI, on treatment service provision, is informed by consultation with organisations and individuals who were contacted in order to obtain their views on treatment services. National and international policy documents were reviewed along with evidence of best practice. An advisory group provided additional input and advice.

Policy Context

AAI identified alcohol treatment as an area of major concern given the current high levels of alcohol related harm and the need expressed in Government policy documents to put in place effective treatment services.

The Strategic Task Force on Alcohol Report 2004 provides specific evidence based measures to the government on how to prevent and reduce alcohol related harm in Ireland. The report based on a public health approach provides the basic policy position on treatment in recommendation S 7. (Appendix I)

Since the Mental Treatment Act of 1945 and the expansion of inpatient treatment in psychiatric hospitals in the decades that followed, to Planning for the Future in 1984 and the subsequent shift to outpatient and community responses, the psychiatric services have had a central role in the treatment of alcohol problems.

The publication of “A Vision for Change”, the Report of the Expert Group on Mental Health Policy, states that the major responsibility for the care of people with addiction problems lies outside the mental health system and that the mental health services responsibility is to respond to the needs of people with addiction and serious mental health problems (Department of Health and Children, 2006). This radical policy shift seems to have been made without evidence to support the move, no clear rationale as to how the decision was made, and no consideration about the impact of this decision on clients/ patients needs.

As noted in The Review of Effectiveness of Treatment for Alcohol Problems (Heather et al., 2006) co- morbidity is common amongst problem drinkers, up to ten percent for severe mental illness, up to fifty percent for personality disorder and up to eighty percent for neurotic disorders. Co-morbidity is also associated with high levels of completed suicide and is so common as to be the norm. It follows that a client centred, needs based service, delivering integrated treatment demands a psychiatric input.

Action 14 of Reach Out, The Irish National Strategy for Action on Suicide Prevention, makes particular reference to the association between alcohol and/ or substance abuse and suicidal behaviour. The Reach Out strategy includes two actions on alcohol:

1. Implement the recommendations of the Interim Report (Department of Health and Children, 2002) and the Second Report of the Strategic Task Force on Alcohol (Department of Health and Children, 2004) on a planned phased basis beginning with a multidisciplinary analysis to agree priority recommendations.

2. Review the current provision of alcohol and addiction treatment services, making recommendations for future service development especially in the context of people experiencing alcohol/addiction problems and mental health problems together (co-morbidity).

While the report of the Working Group on Residential Treatment and Rehabilitation (2007) was primarily concerned with residential treatment and rehabilitation, a number of significant recommendations were made including:

- The four Tier model to be used as a framework for the provision of alcohol and drug services with less intensive approaches, followed by more intensive where necessary (stepped care)
- Full resourcing of the four Tier model in the sense that the development of one Tier was dependent on the development of the others
- Needs assessment of the current capacity of Community based services at Tiers 1, 2 and 3

This comprehensive report makes a range of recommendations on the needs of vulnerable groups and on quality and audit. (HSE, 2007)

The Sustaining Progress Special Initiative of the Social Partnership Agreement selected the alcohol and drug misuse issue as a “major crosscutting issue that requires the mobilisation of a range of resources across sectors, organisations, and individuals and at different levels of Government”. (Government & Social Partners 2006) The emphasis is on working together, building consensus and adopting a problem solving approach to finding practical solutions. The advisory group recognised the need to establish and develop specialist services for alcohol dependency but confined its deliberations to that of screening and brief interventions.

The 2007 Programme for Government has made a commitment to “provide early intervention programmes in all social, health and justice services to ensure early detection and appropriate responses to high risk drinking”. AAI expects the Government and Social Partners to implement this programme of action.

Thus, it can be argued that treatment for alcohol problems is a low priority activity for the Department of Health and Children and the HSE with a corresponding lack of strategic leadership. By contrast, the drugs problem is regarded by the public, politicians and policy makers as the most important substance misuse issue in Irish society.

The purpose then of this paper is to advocate for accessible, appropriate, integrated and effective treatment services for people with alcohol, problems as outlined in European Alcohol

Action Plan 2000- 2005. (World Health Organisation 2000) With a transformation programme and a primary care strategy emerging in health service provision, there now exists an opportunity to put in place more comprehensive and more effective treatment services.

Service Provision

Historically alcohol problems were managed within the Mental Health Services and this usually took place in community settings. Admission to a psychiatric hospital for a psychiatric co-morbidity issue or for detoxification took place at the discretion of the local Mental Health Service in some areas. The Psychiatric Services Planning for Future (Government Publications 1984) report proposed the development of a consultant led local outpatient treatment service. (O'Sullivan 2002)

Alcohol services became in many cases a separate service within the Mental Health Services. While on the one hand this led to some degree of independence and autonomy, on the other hand, due to the lack of investment in Mental Health Services, alcohol services became even more marginalised and forgotten. Coupled with the lack of clarity with respect to responsibility and accountability for alcohol treatment policy within the Department of Health and Children, this has led to marginalisation and a lack of investment in the development of any strategic direction for alcohol treatment.

The Irish College of Psychiatrists has expressed particular concern about the lack of a planned approach for alcohol treatment provision. In a response to the Strategic Task Force on Alcohol Second Report 2004 and with regard to alcohol treatment services, the Faculty of Substance Misuse of the Irish College of Psychiatrists stated that:

“currently treatment of alcohol abuse and dependence consists of the provision of piecemeal outpatient services which have developed out of various local initiatives rather than any coherent and planned strategy. Consequently services vary in quantity and quality across the country. There has been excessive reliance on charitable and religious based treatment services which although experienced and well intentioned are patchy in coverage and function independently”. (Faculty of Substance Misuse Irish College of Psychiatrists, 2005)

This picture of service provision is consistent with what emerged in the consultations carried out for this paper.

The Directory of Alcohol Drugs and Related Services, (Health Promotion Unit 2006) outlines existing services and more specific information is contained in the report of the Working Group on Residential Rehabilitation (HSE 2007).

Existing service provision for alcohol treatment is summarized below:

- The HSE is largely responsible for the organisation and delivery of treatment services (Government / Social Partners, 2006)
- Most services located outside of Dublin are combined alcohol and drugs services
- The HSE provides services at 47 locations (Directory of Alcohol Drug and Related Services)
- Registered charities, private centres and private psychiatric hospitals provide services at 18 locations
- Voluntary agencies provide services for homeless dependent drinkers
- Services are mostly community based
- Centres are primarily staffed by addiction counsellors
- Non specialist services are provided in some general hospitals
- The three Dublin statutory alcohol services cover 10 Community Care areas for the entire eastern region of the HSE (Alcohol Services Managers Report 2006)
- Counselling is the main form of treatment provided with 4 out of 5 receiving same(HRB 2007)

There was no information available on service demand, on the involvement of families in treatment or on the effectiveness of treatment in terms of outcomes.

Consultations

AAI consulted with a range of individuals and agencies in order to obtain their views on treatment services. A wide-ranging response was received from this process outlining a number of needs, issues and concerns. The responses are presented below.

Accountability	There is a perceived lack of ownership of treatment services nationally
	The issue of alcohol services and mental health is contentious with strong support for a repudiation of the Vision for Change position that alcohol treatment should not be part of the mental health brief
	There is equally strong support for the removal of alcohol services from mental health.
	There is a need at national level for a structure to promote best practice on treatment
	Placing alcohol within the remit of local drugs task forces and the regional drugs task forces would allow for better joined up service planning and delivery. There are certain concerns about this proposal for the Dublin region.
Quality	There is a need for a comprehensive national alcohol needs assessment to determine the need for treatment
	There is a need for standardisation of protocols and interventions of evidence based best practice
	Private residential treatment can be available to those with health cover, where public subvention of such service exists there is a need for independent assessment
	There is a lack of inpatient detoxification beds
	There is a limited amount of counselling service provision in the Dublin area
	There is poor service provision out of hours
	There is a need for good quality client information in a range of languages
	Services are seen as fragmented, lacking coordination, operating independently with particular difficulties in the Dublin Area “almost impossible to get beds for public patients”
	There is a lack of ready access by public clients to treatment
People	There is a need for services to be provided in the first instance in

Centredness	peoples own communities, GP Surgeries, community detoxification, primary care settings, A&E Departments
	Partnerships can be developed between voluntary and statutory services using a multi agency, multi systems approach in order to enhance service provision
	There is a need for the development of specialist interdisciplinary out patient teams dealing with alcohol and drugs at Tier 3
	There is a need for counsellors in primary care settings, linked to primary care networks
	There is a need for comprehensive treatment systems, including detoxification outpatient and inpatient tiered systems of care, linked to primary care networks
	There is a need for integrated or shared care approaches and appropriate psychiatric and addiction service provision for clients with psychiatric co-morbidity given that alcohol problems are associated with high levels of co morbidity and completed suicide
Equity	There is a need for a harm reduction approach for the homeless and street drinkers, who have very high levels of alcohol problems, with the expressed need for 24 hour access to detoxification, the need for wet and dry houses and more extended rehabilitation provision.
	There is a need to ensure access to treatment for prisoners and those within the criminal justice system
	There is poor provision of services for travellers and non nationals

The consultations provided valuable insights as to how the level of treatment service provision is perceived; with respect to how services are currently provided and the needs of client groups.

These consultations also suggest several courses of action as to how services could be improved and have important implications for future policy. The responses also inform the recommendations in this paper.

Public Health

There have been many different approaches to how alcohol problems are conceptualized, from society to policymakers and health professionals. These have varied over time from temperance approaches, to the disease concept and latterly the public health approach.

A number of influences have impacted on policy, the most important being the dominance of the disease model as a governing image for society (Room, 2001), for professionals and for parts of the residential and outpatient treatment constituency. The second significant influence concerns public health as a specialized field of knowledge that is not always understood by either the general public or health professionals. (Babor et al., 2003)

AAI's position on treatment is underpinned by the public health approach to alcohol policy. Drawing on the public health approach of the Strategic Task Force on Alcohol Report 2004 and Alcohol No Ordinary Commodity (Babor et al., 2003), AAI views alcohol as contributing to a broad range of health and social problems. The rationale for the public health approach is based on the research evidence and the endorsement of the World Health Organisation.

The public health approach has not as yet, despite its scientific base and conceptual validity been translated into action with respect to treatment, and early intervention across the health and social care systems.

Despite the recognition of the public health approach at policy levels it has not had a significant impact on treatment and intervention, other than influencing the report on the Psychiatric Services, Planning for the Future (1984) and the move towards consultant-led, local outpatient services.

Definitional Issues

There are critical questions of how alcohol problems come to be defined, and understood, as noted in the Alcohol in Europe Report. (Anderson, P. & Baumberg, P 2006) The well known term alcoholism to categorise a disease continues to be used to refer to chronic long term alcohol use with associated physical, mental, social and other consequences, including preoccupation with alcohol and loss of control. The focus on treatment responses based on the disease model principles, as it is asserted here, been crucial to the creation of the public image of alcohol problems.

Hazardous alcohol consumption has been defined as a level of consumption or a pattern of drinking that increases the risk of harmful consequences for the drinker. Hazardous drinkers are drinking at levels that are over recognised limits, either infrequently, in heavy drinking episodes, or more regular excessive consumption.

Harmful alcohol consumption has been defined as a pattern of drinking that causes damage to health, either physical or mental. Harmful drinkers are usually drinking at higher levels than hazardous drinkers and there is clear evidence of alcohol related harm, but many do not understand the relationship between their drinking and the harm they are experiencing.

Alcohol dependence has been defined as a cluster of physiological, behavioural, and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had greater value. A central characteristic is the desire to drink alcohol. Return to drinking after a period of abstinence is often associated with rapid reappearance of the features of the syndrome.

The public health approach to alcohol problems involving a broader view of alcohol problems is taken here and has been adapted from the WHO categorisation.

Alcohol Problems

The Global Burden of Disease Study (WHO 2002) showed alcohol to be the third most detrimental risk factor for European ill health and premature death.

As a risk factor, alcohol was rated more important than being overweight and high cholesterol. Perhaps the most pertinent finding in relation to treatment was that alcohol as a risk factor was deemed to be five times more important than illicit drugs.

Despite this, within the context of substance abuse, the illicit drugs issue, through the National Drugs Strategy, has received considerable more attention than alcohol. The government has provided for structural mechanisms in order to implement policy and provide services for drug users.

The misuse of alcohol is related to a range of problems that includes physical health problems, criminal and offending behaviour, domestic violence, suicide and deliberate self harm, mental health problems, child neglect and child abuse, and social problems including homelessness. (Anderson, P & Baumberg, B., 2006).

It is asserted here that there has been limited commitment to alcohol treatment, that services are fragmented , and despite other pilot projects such as, Irish College of General Practitioner Alcohol Aware Initiative (Anderson et al., 2006) there is no overall strategy in place to provide for service improvement.

As outlined in the Strategic Task Force on Alcohol Second Report 2004, adults in Ireland consume more alcohol per drinker, have higher levels of binge drinking, and as a consequence experience more harm than other Europeans. A number of other reports provide detailed information on trends and patterns and prevalence of alcohol use. (Health Service Executive, 2007)

The extent of alcohol related harm in Ireland is reflected in a number of health related areas as detailed in the table below:

Accident and Emergency Departments

A study of the impact of alcohol on A&E Departments showed that almost a quarter of attendances had an alcohol related injury, with 77% being assessed as intoxicated. (Hope A et al., 2005)

Admissions to Psychiatric Hospitals

14% of admissions are for alcohol disorders. (Daly et al, 2006)

In 2005 there were 2,995 admissions to psychiatric hospitals or units for alcohol related conditions.

Alcohol Related Mortality

Alcohol related deaths increased in line with increased consumption between 1992 and 2002, 61% for chronic conditions and acute conditions +90%. (Strategic Task Force on Alcohol, 2004). 1995-2004 alcohol related deaths doubled to 1,775, 50% of alcohol related deaths occurred to people 50-70 yrs of age.(HRB 2007) Alcohol is a contributory factor in 36% of road traffic deaths

GP Attendances

The Alcohol Aware Initiative, 2006, showed that 22% of drinkers screened were in the hazardous zone, and 17% were in the harmful/dependent zone. (Anderson et al., 2006)

Health Research Board Data

Since 2004, the National Drug Reporting System provides information on treated alcohol problems. The NDTRS does not have all treatment services participating and consequently the treatment figures probably under represent the true extent of alcohol problems. The figures for 2004 and 2005 show that half of those recorded reported alcohol as their main drug.

National Registry of Deliberate Self Harm

47.4% of the male episodes and 39.1% of the female episodes of deliberate self harm involved alcohol indicating the link between alcohol use and suicidal behaviour. (National Suicide Research Foundation 2005)

Public Hospitals

30% of all male patients and 8% of all female patients were found to have an underlying and unidentified alcohol problem. (Hearne et al., 2002) 1995-2004-Number of people discharged with alcohol-related liver disease went up 147%.(HRB 2007)

Treatment Demand In two health board areas (SHB and SEHB) a study revealed that over 70% of those treated for problem substance use reported alcohol as their primary drug.(Health Research Board, 2004),1995-2004 the number of discharges from hospitals went up 92%(HRB 2007) In 2005, 5,527 people received treatment for problem alcohol use(NDTRS).The average annual incidence of treatment seeking per 10,000 of the 15-64 year old population as reported to the NDTRS for 2004-2005 was 10.4

Treatment

There are varying definitions of treatment. (Institute of Medicine 1990) (Babor et al., 2003) All the definitions take a broad view of alcohol problems reflecting a continuum of care including identification, detoxification, brief intervention, assessment, and therapeutic interventions to continuing care. "Treatment refers to the broad range of services including, identification, brief intervention, assessment, diagnosis, counselling, medical services and follow up for persons with alcohol problems". (Institute of Medicine 1990) The aim of treatment is to match the level and intensity of services to the presenting needs. (Models of Care for Substance Misuse Treatment 2002) The overall goal of treatment is to reduce the harm associated with problematic alcohol use. (National Treatment Agency 2006)

Alcohol Problems Continuum

Alcohol related problems are not confined to a minority of dependent drinkers.

Hazardous and harmful drinkers are at the individual level responsible for less harm than dependent drinkers, but they far out number the dependent drinkers and collectively are responsible for a greater amount of alcohol problems (IOM 1990). The concept of a broad spectrum of alcohol related problems distributed along a continuum, it is argued here, represents a valid understanding of alcohol problems.

Historically, treatment provision has been confined solely to specialist provision for the dependent drinker with limited acknowledgement of the needs of the hazardous and the harmful drinker. The implications of a broader definition and classification of alcohol problems has a major impact on who is deemed responsible for treating them. By definition, treatment is not specifically a specialist problem but, a problem that needs to be shared and that requires intervention in a range of settings such as GP and primary care settings, general hospitals, social services, criminal justice system, private and voluntary settings, HSE Community Psychiatric Services and HSE Community Alcohol and Drugs Teams.

Treatment Effectiveness

The World Health Organisation has had an ongoing critical influence on treatment policy over the past sixty years. The approach of the WHO to treatment has evolved from promoting the disease concept (Butler, 2002) with “Alcoholism” as a unitary disorder to promoting the public health approach.

Building on Alcohol Policy and The Public Good (Edwards et al 1994) the most recent WHO alcohol policy document, Alcohol No Ordinary Commodity, (Babor et al., 2003) addresses the scientific basis of treatment and intervention policies from a population health approach proposing that:

- The national planning of services should start with a definition of suitable cases for treatment
- Prevalence data is essential
- Treatment effectiveness issues are critical
- Costs and benefits of treatment need to be addressed

The WHO argue that for treatment services to maximise their public health potential, services will need to be based on objective performance criteria described above. (Babor et al., 2003)

One of the actions of the European Action Plan on Alcohol 2001- 2005 is;

“To ensure that treatment is evidence based, effective and flexible enough to respond to developments in scientific knowledge and treatment technology”. The question of treatment effectiveness is increasingly important given the on going development of evidence based, quality assurance and cost effectiveness. (HSE 2007)

The question then as put by the Institute of Medicine is: “What kind of individuals, with what kind of alcohol problems, are likely to respond to, what kind of treatments, in what kind of settings delivered by what kind of practitioners”. (Institute of Medicine, 1990) The answers can be found in the increasing amount of evidence based scientific research on treatment effectiveness. (National Treatment Agency, 2006) (Project Match 1999) (Miller Carroll et al., 2006)

Drawing on these reviews there are a number of key points that can be made on treatment effectiveness. These are as follows:

Screening

- Screening and early detection of problem drinkers can be carried out by non specialists in a variety of settings, including Primary Care, GP's and A&E using validated screening questionnaires such as the AUDIT.
- Informal methods of screening can allow for the majority of hazardous drinkers to go undetected
- A quantity/frequency question is considered effective in identifying binge drinkers
- The AUDIT is suitable for use in detection of alcohol problems with individuals who have mental health problems

Assessment

- Assessment is essential to care planning and outcome monitoring
- There are a number of instruments that can be combined to develop an assessment package that measures alcohol dependence and allows for outcome monitoring
- The Alcohol Problems Questionnaire is the most commonly used instrument for the measurement of alcohol problems in the UK
- The CIDI (composite international diagnostic interview) is seen to provide a reliable and valid assessment of alcohol dependence.
- The evidence to support standard assessment packages is weak
- A comprehensive assessment can involve readiness to change, levels of drinking and dependence, co morbidity, social functioning, previous attempts at treatment and why they failed
- Higher levels of engagement with treatment are predictive of better outcomes which are affected by client characteristics, including motivation and treatment experiences such as empathy of the helper, perceived helpfulness and usefulness of the treatment services, ease of access and removal of barriers and the inclusion of relapse prevention training

Brief Interventions

- Brief interventions in a variety of settings in different forms can be effective in reducing alcohol consumption among hazardous and harmful drinkers
- There is no evidence for the effectiveness of brief interventions with dependent drinkers
- The effects of brief interventions can last for periods of up to two years
- There is evidence for the effectiveness of brief interventions in A&E in reducing alcohol related consequences
- There is insufficient research done on the effectiveness of brief interventions in non-medical settings, social work settings, criminal justice settings and the work place
- Brief interventions consisting of simple structured advice are effective in reducing alcohol consumption and improving health status amongst hazardous and harmful drinkers in healthcare settings

- Support and training can increase the level of screening and brief intervention in primary health care

Brief Treatments

- Brief treatments involve a variety of interventions. These interventions are less intensive forms of treatment usually a number of sessions and are aimed at the moderately dependent drinker in specialist settings
- There is evidence for the effectiveness brief conjoint therapy, motivational interviewing, and motivational enhancement therapy, with mild and moderately dependent drinkers
- Helpers should not offer motivational enhancement therapy or motivational interviewing until they have the necessary training and competence

Specialist Treatment

- The community reinforcement approach which is seen to be especially relevant to socially unstable and dependent service users
- Social behaviour and network therapy is an effective treatment
- Behavioural self control training, which is considered the most effective approach for those service users with a moderation drinking goal
- Coping and social skills training is an effective treatment approach for those who are moderately dependent
- Cognitive Behavioural Marital therapy is an effective treatment for drinkers and their partners'
- Relapse prevention is an effective and essential component of treatment
- Well structured aftercare is effective in improving outcomes
- Families and significant others benefit from being involved in treatment
- Client centred therapy is an effective form of treatment
- 12-Step facilitation therapy is an effective form of treatment
- Residential 12-Step produces no added benefit compared to other forms of treatment
- AA seems to be effective for those who are suited to it and who attend meetings regularly
- Problem drinkers can have high levels of co-morbidity and integrated treatment using cognitive behavioural therapy delivered by specialist practitioners with competencies in co-morbidity is recommended
- Fidelity to the treatment and practitioner competence are significant elements in treatment outcomes
- The characteristics of the therapists account for 10% to 50 % of the outcome variance
- Evidence based alcohol treatment in the UK is estimated to result in net savings of £5 for every £1 spent on treatment (Heather N. et al., 2006)
- Failure to provide appropriate treatment for harmful and dependent drinkers constitutes a policy of cost ineffectiveness, untreated or inappropriately treated patients, making heavy and repeated demands on the treatment services (Godfrey 1989)

Adapted from: (A Review of the Effectiveness of Treatment for Alcohol Problems, 2006), (Rethinking Substance Abuse, 2006), (The Treatment of Alcohol Problems – A Review of the Evidence, 2003), (Project Match, 1999) and (Broadening the Base of Treatment, 1990)

Drawing on the Directory of Services (Health Promotion Unit, 2006) and HRB statistics the dominant form of treatment is counselling; other approaches include advice giving, group counselling, group therapy, 12 Step and Minnesota, family support, aftercare, relapse prevention and psychiatric assessment.

The pivotal position of counselling within the treatment arena raises issues with respect to quality, standards and best practice. These issues have been addressed in the UK in the Quads Report which places particular emphasis on the need for demonstrable staff competence and adherence to written procedures.

It is also critical that counselling should be care planned, defined as a formal structured counselling approach with assessment, and with clearly defined treatment plans and treatment goals and regular reviews as outlined in Models of Care (2002).

While the IAAAC is concerned with the accreditation of counsellors in Ireland, there is no accreditation of service providers and there are no systems or structures in place for audit, accountability and best practice.

In summary, no single treatment has been identified that is effective for all alcohol problems. A range of treatment approaches has been found to be associated with positive outcomes. The main elements in effective treatment appear to be; a supportive, empathetic helping alliance, the expertise of the counsellor, the readiness of the client to change, the cognitive ability of the client and the availability of a social network that supports the drinking goal and an effective delivery system. (MOCAM, 2006)

Treatment Systems and Services – Best Practice

Best practice in providing planned and integrated treatment services for individuals with alcohol problems and their families is now based on:

- Local treatment systems
- The four tiered approach
- Effective screening and assessment
- Care planning
- Integrated care pathways
- The use of evidence based interventions

(National Treatment Agency, 2006)

The emphasis on treatment systems as opposed to treatment services has been promoted by the Institute Of Medicine (1990), more recently by Models of Care for Substance Misuse Treatment, (UK Department of Health, 2002) and Models of Care Alcohol Misuse 2006 (National Treatment Agency,2006).

The systems approach emphasises the need for co-operation and co-ordination between the various agencies and the various Tiers of service provision and the need for integrated care pathways, with the client at the centre of the process. This approach is consistent with what was learned from the consultations carried out for this paper where the multi-agency and multi-systems approaches are favoured.

AAI sees the development of treatment systems as incorporating a comprehensive range of services and with a mechanism to provide co-ordination as essential.

The Four Tier Model for the Provision of Treatment and Interventions

This conceptual framework has been adapted to the alcohol treatment area as described in Models of Care for Alcohol Misuse. (National Treatment Agency, 2006) The earlier Models of Care for Substance Misuse (Department of Health, 2002) provided a convincing rationale for the advantages of this approach in that:

- It provides a framework to plan comprehensive systems of care nationally, regionally and locally
- It helps to define the function of different services and interventions
- It helps to define the points at which different levels of assessment and care co-ordination take place
- It helps to define exit and entry criteria for each Tier

- It helps to define the target group and maximise targeting of resources

The Four Tier framework outlined in Models of Care describes a stepped care approach with people being helped at the lowest appropriate level of intervention and with the facility to move to a higher or lower Tier on the basis of need.

Tier One Interventions

These include the identification of hazardous, harmful and dependent drinkers, brief interventions, information on low risk drinking and referral where necessary for more intensive interventions. These can be delivered by a broad range of individuals in a variety of settings, primary health care and general hospitals within the criminal justice system, homeless services, social work departments and occupational health programmes. Generalists in these areas are ideally placed to help to reduce the harm for some drinkers by providing advice on road safety, drink driving, the risks related to alcohol and violence and the impact of alcohol on mental health. In order to develop Tier one interventions there is a need for staff to be trained up in harm reduction approaches, advice on limits, and brief interventions.

Tier Two Interventions

Tier two interventions are open access, more extended and provide harm reduction advice, support, brief interventions, triage assessment, referral, self-help, and where necessary, shared care. They are aimed at those with alcohol problems, their families and carers. These interventions can be delivered in Community Addiction Counselling Centres, Primary Health Care, A&E, Psychiatric Services, Social Services, within the criminal justice system, and occupational health services. Staff involved need specialist skills including counselling, brief interventions, motivational interviewing and the necessary support from Tiers three and four.

Tier Three Interventions

The interventions at this level involve the provision of a community based specialist service that is provided by a multidisciplinary team. The interventions provided include comprehensive assessment, care planned treatment, community detoxification, evidence based psychosocial therapies and liaison services for psychiatric and medical services. These services are an essential component of a treatment system, to provide for the needs of more complex cases and critically to provide support to Tiers one and two. These services which have formed the basis of the statutory community response since Planning for the Future in 1984 have developed for the most part despite of, rather than because of any coherent planned national response. Such services are often uni-disciplinary and for the most part are provided by counsellors. While there may be access to other disciplines within that type of service, best practice indicates that a full multi-disciplinary team should be in place.

Tier Four Interventions

The interventions at this level, which were the main focus of the Report of the HSE Working Group on Residential Treatment & Rehabilitation, Substances Users (HSE 2007) include the provision of residential specialist treatment using a care planned approach by a multidisciplinary team and more extended rehabilitative care. Other interventions in inpatient settings are assessment detoxification, psychosocial interventions, support training and shared care to other Tiers.

For those who require specialist care, dedicated specialist services are regarded as the best option in terms of overall efficient use of health care resources. The HSE report above noted that “there was an inadequate level of residential services, throughout the country, in particular detoxification services, rehab services, public residential services and services for special needs groups, such as homeless people, young people women with children and new /ethnic communities”.

As noted in The Rehabilitation Report the treatment of those who are homeless and street drinkers need to be given priority at Tier 4. It is clear that the medical needs of those who need detoxification or who have more complex needs such as psychiatric problems are not appropriately addressed.

Integrated Care Pathways

Integrated care pathways describe the nature and the expected course of treatment for a client with a predetermined treatment plan. At national level the development of integrated care pathways is one of the transformation priorities of the HSE given that many services are “fragmented, disjointed and difficult to navigate” (HSE, 2006). Services for alcohol problems are no exception to this.

The development of integrated care pathways for alcohol problems, (MOCAM, 2006) is recommended on the basis that persons with alcohol problems can have a range of problems needing a coordinated approach to treatment and that a range of services may be involved at the same time or consecutively. A person with alcohol problems may have ongoing and developing needs that require referral to different Tiers of service over time, and integrated care pathways can ensure a consistent approach.

Another valuable aspect of the development of integrated care pathways at local level, within a systems approach, is the mapping of the level of service provision where gaps and overlaps can be identified. Integrated care pathways need to be formally defined and developed at national level.

Towards Quality and Fairness

The health service reform programme which is now in train is primarily concerned with the realignment of structures and systems, using a patient centered model.

Some of the need for change is outlined in the HSE transformation programme (HSE, 2006) with services fragmented and disjointed and difficult to navigate. There is increased commitment to the delivery of higher quality and more effective services that are underpinned by research evidence and performance measurement.

The major reform is the development of the primary community and continuing care infrastructure (Department of Health and Children, 2001) with the opportunity for the development of systems and services for alcohol problems in primary and continuing care. This should allow for early identification and screening and opportunistic brief interventions.

In order to meet service users' needs and to enhance service provision in line with the public health approach and best practice, it is now essential that the primary care element of a systems approach to the treatment of alcohol problems be developed.

Conclusion

In this paper, it is argued by AAI that there is a compelling need to develop a comprehensive treatment system for those with alcohol problems. This is necessary given the evidence of the impact of hazardous, harmful and dependent drinking on the areas of health and social care. While the effect on the health services is substantial, criminal justice, social services and the workplace are also affected. There is also the effect of alcohol problems on children and families with associated conflict, and marital breakdown.

The need for treatment is also documented in an array of Government policy documents and in the views of those consulted. The case for treatment is supported by the evidence of the effectiveness of treatment and indeed the cost effectiveness of treatment.

The consultations revealed a critical appreciation of the gaps in service provision, the needs of certain groups and the need for a Tiered approach and a frustration with the lack of concerted action to improve treatment. The gaps in service provision were matched by the gaps in the organisational infrastructure at the highest levels in terms of accountability and responsibility. Existing service provision is, as noted above, inadequate to meet the needs of the client groups. There are problems in service delivery with a focus on specialist services and limited screening and brief interventions. While there is a policy and professional commitment to the public health approach, vis a vis treatment, this has not been reflected in the development of more comprehensive services.

There is a need to improve treatment services, and there is also an opportunity with the new structures, processes and systems that are being developed in the HSE for an increased emphasis on quality, performance measurement and accountability.

Measured against the European Action Plan and the guiding principles of equity, accountability, quality and people centredness in *Quality and Fairness: A Health System for You* (2001), the treatment systems for alcohol problems in Ireland are inadequate to meet the needs of people with such problems and the needs of their families and remain a low priority despite the evidence of harms, and the policy rhetoric.

The apparent indifference by the Government to the public provision of treatment for people with alcohol problems represents the biggest challenge.

In order to address this major public health problem AAI urges the Government, the HSE and all key stakeholders to act by taking account of the recommendations of this paper.

“Are we content to allow the majority of people with drinking problems to remain unrecognised, and unhelped, or do we wish to encourage more active intervention?” (Shaw et al., 1978).

Recommendations

	Cross Reference
1. The development of a combined strategy for alcohol and drugs	National Drugs Strategy 2001-2008, Action 80; STFA 2004 R1
2. A national needs assessment for alcohol problems and a review of treatment provision for dependent drinkers to be prioritised	Report of the Working Group on Residential Rehab Substance Users 2007
3. Provide secure and sustained investment in alcohol treatment systems	
4. Designation of tax from the sale of alcohol to be put to the establishment and implementation of national alcohol treatment systems and services	
5. The establishment of a national agency/structure to provide guidance on audit, quality, governance and cost effectiveness and accreditation of services	
6. The development of a systems approach, acknowledging the need for partnerships, and the need for coordination and collaboration between services and agencies, is necessary	National Drugs Strategy 2001-2008
7. The development of client centred, needs led treatment provision in line with Health Services transformation programme	HSE Transformation Programme
8. The establishment of a national screening protocol for early intervention of problem alcohol use	STFA 2004, Sustaining Progress Special Initiative 2006
9. The development of integrated care pathways and a planned and resourced approach to the 4 Tier system	Working Group on Residential Treatment and Rehabilitation 2007
10. The development of care pathways protocols and procedures for dedicated community detoxification	Working Group on Residential Treatment and Rehabilitation 2007
11. The development of pilot projects in early intervention in a range of settings including the criminal justice system, social work settings and the work place	Programme for Government 2007
12. The development of treatment services for prisoners and those within the criminal justice system	Prevent Homelessness in Dublin 2005-2010 Strategy
13. The development of resources to meet the needs of travellers and non nationals with special attention to be given to overcoming barriers in accessing services.	
14. Planning and development of services using a harm reduction approach in response to the particular needs of homeless people including wet and dry houses, access to detoxification and extended rehabilitation	Prevent Homelessness in Dublin 2005-2010 Strategy
15. It is recommended that the established role of counselling within the addiction services be strengthened and developed	Robinson/Velleman Review of Health Board Alcohol and Drugs Services
16. Addiction services should be planned so that the environment for counselling service delivery is ensured as feedback from some services indicated the significant difficulties encountered in trying to deliver counselling in certain clinical settings.	

17. Director/Manager of Counselling to be established in each region to co-ordinate and develop the delivery of a comprehensive and accessible counselling service within the addiction services and within Primary care and other settings	Robinson/Velleman Review of Health Board Alcohol and Drug Services
18. Research on treatment outcomes for alcohol problems.	
19. The development of and resourcing of services for patients with psychiatric co-morbidity, as a matter of urgency.	Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland 2004
20. It is recommended that a multidisciplinary team supports the delivery of therapeutic interventions at Tier 3 and Tier 4	Health Service Transformation Programme; Quality and Fairness
21. Put in place accessible alcohol and drug youth counselling services in each region	Report of Working group on Treatment of under 18 yr olds DoHC 2005
22. Provide addiction counsellors to primary care teams/networks	Primary Care; A New Direction DoHC 2001
23. Support and counselling services for family members affected by problem drinkers should be provided within the Treatment system	
24. Review and develop the substance misuse curriculum at undergraduate and postgraduate levels for health care professionals.	
25. Provide continuing professional development training for all health care professionals in brief interventions.	
26. Provide an accredited training programme for qualified counsellors and psychotherapists to enable them to work specifically with clients presenting with substance misuse problems.	

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Appendix I European Charter on Alcohol

Ethical Principles and Goals

In furtherance of the European Alcohol Action Plan, the Paris Conference calls on all Member States to draw up comprehensive alcohol policies and implement programmes that give expression, as appropriate in their differing cultures and social, legal and economic environments, to the following ethical principles and goals, on the understanding that this document does not confer legal rights.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

Ten Strategies For Alcohol Action

Research and successful examples in countries demonstrate that significant health and economic benefits for the European Region may be achieved if the following ten health promotion strategies for action on alcohol are implemented to give effect to the ethical principles and goals listed above, in accordance with the differing cultures and social, legal and economic environments in each Member State:

1. Inform people of the consequences of alcohol consumption on health, family and society and of the effective measures that can be taken to prevent or minimise harm, building broad educational programmes beginning in early childhood.
2. Promote public, private and working environments protected from accidents and violence and other negative consequences of alcohol consumption.
3. Establish and enforce laws that effectively discourage drink-driving.
4. Promote health by controlling the availability, for example for young people, and influencing the price of alcoholic beverages, for instance by taxation.
5. Implement strict controls, recognising existing limitations or bans in some countries, on direct and indirect advertising of alcoholic beverages and ensure that no form of advertising is specifically addressed to young people, for instance, through the linking of alcohol to sports.
6. Ensure the accessibility of effective treatment and rehabilitation services, with trained personnel, for people with hazardous or harmful alcohol consumption and members of their families.
7. Foster awareness of ethical and legal responsibility among those involved in the marketing or serving of alcoholic beverages, ensure strict control of product safety and implement appropriate measures against illicit production and sale.
8. Enhance the capacity of society to deal with alcohol through the training of professionals in different sectors, such as health, social welfare, education and the judiciary, along with the strengthening of community development and leadership.
9. Support nongovernmental organisations and self-help movements that promote healthy lifestyles, specifically those aiming to prevent or reduce alcohol-related harm.

10. Formulate broad-based programmes in Member States, taking account of the present European Charter on Alcohol; specify clear targets for and indicators of outcome; monitor progress; and ensure periodic updating of programmes based on evaluation.

Appendix II European Action Plan

Summary

The meaning of drinking alcohol varies, and for many people having an alcoholic drink is part of social life. The harm that can be done by alcohol extends beyond the individual drinker to families and communities across the whole population. Alcohol products are estimated to be responsible for 9% of the total disease burden within the Region. They are linked to accidents and violence and are responsible for a large proportion of the reduced life expectancy in the countries of the former Soviet Union. Reducing the harm that can be done by alcohol is one of the most important public health actions that countries can take to improve the quality of life. Since 1992, the European Alcohol Action Plan (EAAP) has provided a basis for the development and implementation of alcohol policies and programmes in Member States. The aim of EAAP for the period 2000–2005 is to prevent and reduce the harm that can be done by alcohol throughout the European Region.

The overall objectives are to:

- ❖ generate greater awareness of, provide education in, and build up support for public health policies that address the task of preventing the harm that can be done by alcohol;
- ❖ reduce the risk of alcohol-related problems that may occur in a variety of settings such as the home, workplace, community or drinking environment;
- ❖ reduce both the breadth and depth of alcohol-related harm such as fatalities, accidents, violence, child abuse and neglect, and family crises;
- ❖ provide accessible and effective treatment for people with hazardous and harmful alcohol consumption and those with alcohol dependence;
- ❖ provide greater protection from the pressures to drink for children, young people and those who choose not to drink alcohol.

The ten strategies set out in the European Charter on Alcohol provide the framework for EAAP during the period 2000–2005. The Action Plan indicates what should be achieved (outcomes) and how that can be achieved (actions). Each Member State is encouraged to implement the actions most likely to reduce the harm that can be done by alcohol in that country. The WHO Regional Office for Europe will play an active role in supporting the Action Plan in five key areas:

- (a) advocate the protection of health and identify alcohol related policies and practices that harm health;

(b) provide a focus for information on health through its alcohol-related monitoring and evaluation systems and cooperate with its major partners such as the European Commission;

(c) give support to Member States in the development of effective alcohol policies, utilizing its research and science base;

(d) provide evidence-based tools and guidelines for turning alcohol policies into action;

(e) provide leadership, technical support and coordinated action through collaborative networks across Europe.

Appendix III Strategic Task Force on Alcohol Report 2004

Excerpt

S7. Put in place effective treatment services

R7.1 Establish a national screening protocol for early identification of problem alcohol use, for all relevant sectors of the health care system.

R7.2 Put in place early intervention programmes:-

- a. In primary care to introduce and establish brief intervention as standard practice to reduce high risk and harmful drinking patterns.
- b. In the emergency room and general hospital for those presenting with alcohol related problems.
- c. In health clinics where excess alcohol is a contributory factor in presenting conditions (emergency contraception, STIs, parasuicide, mental illness).
- d. For those convicted in the courts of alcohol related offences (public order, drink driving etc).
- e. For those under 18 years in the Garda Juvenile Diversion Programme, the Springboard Initiative and other community based interventions.

R7.3 Require all third level colleges to provide support services (brief intervention, counselling) for students, as outlined in College Alcohol Policy Framework document.

R7.4 Require workplaces, as part of employee health and welfare, to have procedures to address workplace alcohol related problems.

S7.2 Specialist Treatment

Alcohol dependency, defined as a chronic disorder characterised by a cluster of recognisable symptoms including physical withdrawal and loss of control over one's drinking, requires specialist treatment. While brief intervention is not considered beneficial for alcohol dependent individuals, the screening aspect can act as a referral pathway into appropriate treatment.

R7.5 Put in place adequate and accessible youth counselling alcohol/drugs services in each Health Board region.

R7.6 Establish an inventory of treatment services and make available to the Courts when dealing with offences arising from alcohol abuse.

R7.7 Provide a range of treatment services in each health board region that are effective, accessible, appropriate and integrated with other service areas.

R7.8 Develop explicit pathways of care for those seeking treatment for alcohol-related problems.

R7.9 Promote greater awareness of where people (individual drinker, children and family members) can access help and obtain treatment services.

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