THE LORD PRESIDENT'S REPORT ON ALCOHOL MISUSE AND THE IMPLICATION FOR ALCOHOLISM SERVICES IN SCOTLAND

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It is the purpose of this paper to review the specialist alcoholism residential services in Scotland for each Health Board Area following the publication of the Lord President of the Councils report "Action Against Alcohol Misuse" (1). To apply a systems approach to estimating the required capacity of alcoholism treatment services. Finally a comparison is made of Scotlands existing services with those in Norway and Alberta.

To assess adequate provision of services it is necessary to measure the extent of alcoholism in Scotland. The most accurate measure of Scotlands actual consumption of alcohol would be the number of litres of absolute alcohol consumed by the population per head. Unfortunately the Scottish alcohol consumption is not available as a separate figure but is included together with figures for the rest of the UK. The UK as a whole ranks 11th of leading European Nations in terms of consumption of 100% absolute alcohol with a level of 7.5 litres per head of population in 1989 or 9.3 litres per adult head over 15. (2)

It is of course essential that this figure for Scotland is established. Alberta which is a province of Canada has been able to calculate this figure (3), Scotland as a country must know such a vital statistic. In the absence of this figure for Scotland we have to look at other indicators of alcohol related harm which point to the extent of alcohol problems in this country. One indicator is the number of alcohol related deaths. over a 10 year period up to 1989 alcohol related deaths averaged 283% greater each year in Scotland than in England (Table 1). If we take the death rate due to liver cirrhosis for Scotland (another indicator of alcoholism prevalence) for the 10 years to 1989 and compare it with

England and Wales (see Table 2) the average over that period is 87% greater in Scotland. Suicide is another indicator of alcoholism in the community and that was 42% greater in Scotland than in England in 1989 (4). The rate of miscellaneous deaths due to violence such as murders is approximately 98% greater in Scotland than in England and Wales.(4) Deaths due to accidents which are often alcohol related and would include such things as head injuries but excluding motor vehicle accidents are 60% greater in Scotland (4) than in England and Wales.

Paton has estimated that in the average General Practice of 2,000 adults there will be 135 heavy drinkers, 40 problem drinkers and 17 alcohol dependent persons or alcoholics (5). We have conservatively increased these figures by 50% for Scotland suggesting that 14.4% of adults in a practice or by inference of the adult population are drinking levels which place their health at risk. The definition of adult is persons over the age of 15. This figure for Scotland might in fact be a conservative "guesstimate"

Since Alcohol Concern (6) also calculates that 15% of the UK population as a whole are drinking amounts that could endanger their health. No doubt they would agree on a higher figure for Scotland.

Similar figures have been produced by the office of Health Economics in the 1970's (7) and the Scottish office state that 24% of men and 7% of women are drinking to excess (8).

Adopting this figure of 14.4% of the adult population in Scotland who exhibit harmful or dependent levels of consumption we have produced Table 3 which lists numbers of adults within each Health Board area in Scotland who are drinking amounts which could endanger their health.

ASSESSING THE NEED FOR SERVICES

In June 1992 Maynard of the Centre of Health Economics in York published a report entitled "A Health Strategy for Alcohol. Setting Targets and Chosing Policies".(9) In this report he stated "that District and Regional health Authorities have an important role in assessing the need for services and the work of Rush (1990) (10) in Ontario provides a useful model".

Brian Rush of the Addiction Research Foundation in Ontario published a paper in 1990 in the British Journal of Addiction and it describes a model for estimating the required capacity of alcohol treatment systems at the local and regional level. His model was specific to Ontario. However his general approach and many of his underlying concepts and assumptions have wider application in assessing the need for alcohol treatment services. Rush produced a quantitive planning model that indicates how much of each type of treatment was required per population base or per estimated number of people in need. I am particularly pleased that Rush includes the whole range specialist treatment services as called for in the recent government report not just residential services in which I act, personally involved.

LORD PRESIDENT'S OF THE COUNCIL REPORT "ACTION AGAINST ALCOHOL MISUSE" (1)

A year after Rush's work was published the UK Lord President of the Council published a report entitled "Action Against Alcohol Misuse". In this report it is stated that government policy is committed to providing help for problems drinkers and their families. That in addition to the generic services which are important there should be a comprehensive and integrated network of specialist advice and treatment services. These specialist services "may be provided by the voluntary and statutory agencies and by the private sector" states the report. The integrated range of specialist services now government policy are to be available in each area and will need to include in the first place health education promotion and prevention. In the second place, advice, counselling and group

work support for people who recognise the problem and wish to stop it from getting worse and for members of the families of problems drinkers whose lives may have been affected. In the third place, detoxification, in either a residential, day care or domiciliary setting, for people who seek help for a serious alcohol problem; this can be dangerous without access to medical support. Finally and in the fourth place the range of services should include rehabilitation, in residential , day care or domiciliary settings, providing high, medium and low levels of care.

The government's policy is that- the development of services for alcohol misusers is to be taken forward in the context of the NHS and Community Care Act 1990. Health Authorities in England and Wales and Health Boards in Scotland will decide upon the health care services that are to be made available for alcohol misusers in their areas, and either provide these services or arrange to purchase them from a range of providers including private and voluntary bodies. The local authorities will assume responsibility for the planning and purchasing of social care facilities for alcohol misusers.

Under these new health reforms the government have stated that they wish to see a flourishing independent sector. it therefore follows that the independent sector should receive an economic rate for health care, since charging and remuneration at economic rates, which include capital charges, have become essential components of the NHS internal market.

RUSH'S SYSTEM

Having established government policy and also the number of people in Scotland who are "in need" (Table 3) [ie number of heavy, problem and dependent drinkers] we can accordingly apply Rush's system as recommended by Professor Maynard to estimate treatment services for each Health Board area in Scotland. In this way we can gauge the ideal service provision in Scotland.

It is not the intention in this paper to provide a complete description and analysis of Rush's system. The intention is to merely apply the system to Scotland with the hope that it will motivate the Authorities to study Rush's ideas in detail and then to review the current alcoholism service provision.

Rush defines the various service provisions as follows.

Detoxification

Detoxification services provided to patients intoxicated or in withdrawal. They may be under medical supervision or in a non medical detoxification centre.

Out-patient Treatment

This is provided on a non residential basis mainly in regular scheduled services eg one to two hours per week.

Day Treatment

This is intensive structured non residential treatment usually provided 5 days per week eg three to f our hours per day.

Short Term Residential Treatment

Treatment provided for an intensive structured period of time while the patient resides in the unit. The length of treatment is typically up to 30 days.

Long Term Residential Treatment

This is treatment and/or rehabilitation provided for a period of time longer than 30 days. These units will include extended care units and half-way houses.

Aftercare

The sources or services that provide on-going encouragement support and additional services needed following a patients' completion of a treatment plan.

APPLICATION OF RUSH'S MODEL

Rush has determined that of persons "in need" there will be a demand for specialist services from 15%. Of the remaining 85% there will be no therapeutic contact or they will be in contact with the generic services, general hospitals, the law or self help organisations.

Of the 15% seeking specialist services, Rush estimates that

Detoxification services should be planned for 40%, out-patient treatment services should be planned for 25%, Day treatment services should be planned for 14%,

Short term residential treatment should be planned for 5%, Long term residential treatment should be planned for 6%, Rush's paper also indicates forecasts for assessment, case management and aftercare services.

Capacity guidelines for specialised treatment of Scottish estimated "in need" population per Health Board are shown using the above percentages in Table 4. The situation regarding existing provision of specialist beds is shown in Table 5. The number of beds in Scotland amount to 390 contained in 22 facilities. Rush's model applied to Scotland requires 3,900 beds, 10 times greater than the existing provision.

COMPARISON WITH OTHER COUNTRIES

It is always informative to compare what is happening now in Scotland with the services provided in other countries. We are therefore comparing the Scottish service provision with the provision of services in Norway, which was the host of the 1988 ICAA Convention and Alberta, which was the host of the 1984 ICAA Convention.

Evidence from Scottish Ministerial correspondence indicates that the Home & Health Department at the Scottish Office is satisfied that the health care services for the alcoholic "in need" population of Scotland can be met by a voluntary general services network of Counsellors offering one hour fortnightly sessions to clients and a few scattered beds and day units with any further demand being admitted to general psychiatric and general hospital wards.

The services in these two countries we are using as a comparison are mainly provided by statutory and not for profit organisations and therefore there can be no accusations that the services provision is profits led as may be the case in the United States.

If we consider the services for the care of alcoholics and alcohol misusers in Scotland without a comparison with other developed countries (Table 5), the Health Authorities, Government Authorities, Press and opinion leaders may consider our service provision to be adequate. Studying the services in other countries may address this complacency.

Both Norway and Alberta, a province of Canada, have Populations easily comparable to Scotland. In addition both countries are in the Northern hemisphere and are mainly beer and spirit drinking and therefore similar to Scotland in the type of consumption.

ALBERTA

Alberta is a province of Canada with a population of 2.5 million. Alcohol consumption is mainly beer and spirit drinking many of this population are of Scottish extraction consumption in Alberta (Table 6) has been as high as 13.3 litres in 1981 reducing to 9.9 litres per head in 1989. Table 7/1 lists Liver Cirrhosis figures for both Alberta and Scotland. As consumption has decreased in Alberta so has the liver cirrhosis death rate which has decreased from 8.8 to 5.5 per l00,000 population.

Interestingly and as might be expected as UK consumption has increased so has the prevalence for liver cirrhosis in Scotland.

The reduction in alcohol consumption in Alberta has occurred despite a relaxation in regulations regarding sales and consumption. Whilst one cannot state that there is a direct causal relationship between service provision in Alberta and reduced consumption it seems highly likely that such a relationship exist.

The Alberta services can only be described as an excellent role model for Scotland and other countries. The government gives a high priority to all addiction services and even remote areas will have a range of services. There is a good balance between in-patient and out-patient care and aftercare and a commitment by the government to maintain services. 38 institutions in Alberta provide a total of 972 beds. There is widespread availability of Alcoholics Anonymous meetings to provide the long term support for alcoholics.

NORWAY

Norway has a population of 4.2 million. Alcohol is very expensive in Norway and the government has for a long time imposed strict regulations over the use, production and sale of alcohol.

This has resulted in a relatively low consumption of alcohol 4.9 litres per head of population in 1990 and the indicators of social and individual damage are accordingly lower than in many other countries. However, in addition to official figures for consumption private imports, home brewing and a illegal distilling must render the actual consumption much higher.

At the beginning of 1990 there were 137 institutions with 2,600 specific beds for treatment of alcohol and drug misuse. The policy of the Norwegian government today is to provide a comprehensive range of specialist services in each of the 19 counties.

DISCUSSION

It is the author's impression that the extent and the seriousness of the illness of alcoholism together with alcohol related harm in this country are greatly underestimated. There are two bodies mainly involved in funding alcohol research; the drinks industry and the government Scottish office. The drinks industry wishes to portray the consumption of alcohol as a healthy and wholesome activity. The reality is that if everyone maintained sensible consumption levels it would lead to a drastic reduction of profits for the drink industry. For instance what will be the affect on the drink industries turnover if the 3% of the population in Scotland who consume 30% of the alcohol consumption reduced their drinking to healthy level (11) Likewise if the full and stark reality was known and accepted of the extent of the damage caused by alcohol consumption the government would have to provide considerably greater funding to deal with treatment and harm reduction and prevention.

The figures produced for the existing services in Scotland demonstrate the paucity of such services. The talk of minimal intervention" network of voluntary agencies and "home detoxification" and so on 'is music' to the ears of Treasury officials and authorities planning health care.

These low budget services have a role as part of the integrated range of services. The danger is that total reliance is being placed on these low budget services at the expense of equally important intensive day and residential services, to the extetnt have become negligible in Scotland. There are only 22 specialist institutions in Scotland with a total of 390 beds.

If the Scottish Office is to seriously meet its target as outlined in the recent white paper "The Health of the Nation" it would need to match Alberta's reduction and reduce the incidence of heavy drinking by 20% by the year 2000, it could achieve this by increasing treatment services to levels suggested by Rush's model or at least by increasing the services to the standards in Alberta. I am certain that the resultant savings would more than pay for themselves because of the reduction in the cost of other services. Imagine for instance the savings from a reduction by 30% of serious head injuries in Scotland's hospitals and a similar reduction in Glasgow's alcohol related fires.

If the government does not wish to provide these services but still wishes to achieve its target by 2000 the only alternative, is to substantially increase the cost of alcohol which is politically unacceptable to all main political parties.

The government report in December 1991 must not be put on the shelf to gather dust.

Doctors, Health Boards and the government must have more compassion for the sick alcoholic "who deserve treatment " (WHO) and are worthy of our care.

Having worked in the treatment field for 10 years I have privileged to have been involved in the onset of recovery of many patients. I have shared in the joy of many individuals and their families who were broken mentally, spiritually, emotionally and physically and who were able with professional help to experience the happiness of normal living.

The national government has called for a specialist ran integrated services in each area. We in Scotland must respond.

Table 1

ALCOHOL RELATED DEATH RATE PER 100,000 POPULATION IN SCOTLAND, ENGLAND & WALES

Death Rates		80	81	82	83	84	85	86	87	88	89	9 0
Scotland		8.57	8.15	7.98	7.82	7.99	8.86	8.40	8.47	9.48	9.92	9.33
England & Wales	2.62	2.57	2.58	2.62	3.01	3.12	3.25	3.38	3.56	3.89		

1 Number of alcohol related deaths due to ICD No's 291, 303, 305.0, 425.5, /1.0, 571.1, 571.2 and 571.3 as well as toxic effect of alcohol.

2 Data from the Scottish Council on Alcohol 'Alcohol Statistics' 1992.

TABLE 2

CIRRHOSIS DEATH RATE IN SCOTLAND, ENGLAND AND WALES 1980-90

	80	81	82	83	84	85	86	87	88	89	90
Scotland	3.1	3.2	3.2	3.5	3.8	3.8	3.4	3.6	4.0	4.7	4.9
England & Wales	1.5	1.6	1.6	1.8	1.9	2.0	2.1	2.2	2.3	2.6	

1 Source: Scottish Council on Alcohol 'Statistics', 1992.

2 The units used refer to the total population.

3 Death rate per 100,000 inhabitants.

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TABLE 3

POPULATION AT RISK IN EACH HEALTH BOARD AREA

HEALTH BOARD AREA

HEALTH BOARD AREA (AGE 15 OR MORE)	POPULATION DEPENDENT DRINKERS	HEAVY DRINKERS	PROBLEM DRINKERS	
Argyle & Clyde	355,138	35,958	10,655	4,528
Ayrshire & Arran	303,000	30,680	9,090	3,864
Borders	85,550	8,598	2,567	1,091
Dumfries & Galloway	120,384	12,189	3,612	1,535
Fife	279,450	28,295	8,384	3,563
Forth Valley	221,065	22,383	6,632	2,819
Grampian	410,142	41,528	12,304	5,229
Greater Glasgow	756,003	76,545	22,680	9,639
Highland	163,242	16,529	4,898	2,082
Lanarkshire	449,760	45,539	13,493	5,735
Lothian	619,714	62,747	18,591	7,902
Orkney Island Council	15,744	1,596	470	201
Shetland Island Council	17,318	1,754	519	221
Tayside	322,864	32,690	9,686	4,116
Western Isles	25,153	2,547	755	321

1. These figures are estimates based on data published in "An ABC of Alcohol, 1988" by the British Medical Journal (Edited by A Paton) where it is suggested that "A general practitioner with 2,000 adult patients on his/her list will have something like 135 heavy drinkers, 40 problem drinkers and 17 who are addicted to alcohol".

2. The figures quoted for each Health Board are estimates assuming the Scottish figures to be at least 50% higher than the equivalent UK figure judging by the death-rate from alcohol-related disease (see previous Tables).

TABLE 5

IN-PATIENT FACILITIES IN SCOTLAND - SPECIALIST BEDS

HEALTH BOARD AREA	DETOXIFICATION	SHORT TERM	LONG TERM
Argyle & Clyde	17	16	44
Ayrshire & Arran	0	12	0
Borders	8	39	20
Dumfries & Galloway	4	0	0
Fife	0	0	0
Forth Valley	4	0	0
Grampian	6	27	35
Greater Glasgow	8	0	56
Highland	0	26	30
Lanarkshire	4	0	0
Lothian	2	18	14
Orkney Island Council	0	0	0
Shetland Island Council	0	0	0
Tayside	0	12	0
Western Isles	0	0	0
TOTAL SCOTLAND (Pop 5.OM)	53	150	187
Estimate for Scotland using			
Rush's System	568	615	2718
Alberta (pop 2.5m)	264	462	226
Norway (pop 4.2m)	250	970	1400

1. Only specialist units have been included.

2. Detoxification in general wards and "at home" not included

3. Assuming 6 month occupancy for residents

4. 8 of the detoxification beds are provided outside the NHS. 72 of the short term beds are provided outside the NHS. There are no beds provided by the NHS for long term care.

TABLE 6

ANNUAL CONSUMPTION OF ALCOHOL IN THE UNITED KINGDOM NORWAY AND ALBERTA PROVINCE, CANADA 1980-1990

COUNTRY	80	81	82	83	84	85	86	87	88	89	90
Alberta	10.1	13.3	12.8	12.1	11.6	11.7	11.2	10.6	10.3	9.9	
Norway	5.98	5.32	4.83	4.85	4.98	5.22	5.27	5.38	5.26	5.08	4.99
United Kingdom	9.2	8.8	8.6	8.9	8.9	9.0	9.0	9.2	9.4	9.4	9.3

1. Figures given are for the adult population ie those aged 15 years or more.

2. The units used are Litres of 100% Absolute Alcohol/person/year.

3. Source: Scottish Council on Alcoholls Alcohol Statistics', 1992. The figures for Alberta, Canada were -derived from Statistics Canada Catalogue 63-202 for 1980/81 to 1984/85 and from Statistics Canada Compendium of Public Sector Statistics for 1985/86 to 1989/90. The Norwegian figures are from Rusmidler i Norge, 1991.

TABLE 7/1

LIVER CIRRHOSIS DEATH RATE IN SCOTLAND AND ALBERTA PROVINCE, CANADA 1980-1990

COUNTRY	80	81	82	83	84	85	86	87	88	89	90
Alberta	8.8	8.8	8.0	8.2	6.5	5.1	5.9	5.3	5.4	5.5	
Scotland	4.1	4.2	4.1	4.4	4.8	4.7	4.3	4.6	5.0	5.9	6.0

1. sources : Statistics Canada Catalogue No 84~203.
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2. only alcohol related deaths are included, ie I.C.D. NoIs 571.0, 571.1, 571.2, and 571.3; Alcohol fatty liver, Acute alcohol hepatitis, Alcohol cirrhosis of liver and Unspecified alcoholic liver damage, respectively.

3. Units are deaths/100.000 population aged 15 years and over.

TABLE 7/2

LIVER CIRRHOSIS DEATH RATE IN SCOTLAND AND NORWAY 1980-1990

COUNTRY	80	81	82	83	84	85	86	87	88	89	90
Norway	6	5	5	6	6	7	7	8	7	6	
Scotland	3	3	3	3	4	4	3	4	4	5	5

1. Total death rate/year/100,000 inhabitants.

2. The figures refer to I.C.D. numbers 571.0, 571.1, 571.2 and 571.3 only.

3. The Scottish figures are derived from those published by the Scottish Council on Alcohol, 1992; the Norwegian figures from estimates of death-rates published in Rusmidler i Norge, 1991

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