Consensus Statement on Alcohol Treatment Services in Scotland

SHAAP
Scottish Health Action on Alcohol Problems

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Royal College of Nursing Scotland

Scottish Health Action on Alcohol Problems

Scottish Health Action on Alcohol Problems (SHAAP) is a partnership of the Medical Royal Colleges and the Faculty of Public Health in Scotland and is based at the Royal College of Physicians of Edinburgh (RCPE). Using the best available evidence, SHAAP provides the authoritative clinical voice on how policy makers and clinicians can reduce alcohol-related harms in Scotland.

Royal College of Nursing Scotland

The Royal College of Nursing is the world's largest nursing union and professional body. We represent over half a million nurses, student nurses, midwives and nursing support workers in the UK and internationally. As a member-led organisation, we work collaboratively with our members to: influence governments and other bodies, improve working conditions, and campaign on issues to raise the profile of the nursing community.

The Royal College of Psychiatrists Scotland

As the professional medical body for psychiatry in Scotland, we set standards and promote excellence in psychiatry and mental healthcare. We lead, represent and support psychiatrists nationally to government and other agencies, aiming to improve the outcomes of people with mental illness, and the mental health of individuals, their families, and communities. We are a devolved nation and council of the Royal College of Psychiatrists. We have over 1,400 Members, Fellows, Affiliates and Pre-Membership Trainees in Scotland.

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Executive summary

Informed by SHAAP-commissioned research on hospital alcohol services in Scotland, and a workshop in 2024 attended by healthcare professionals and third sector colleagues, SHAAP, the Royal College of Psychiatrists Scotland (RCPsych Scotland) and the Royal College of Nursing Scotland (RCN Scotland) have produced this consensus statement to call for clear, well-integrated pathways to support treatment and recovery for patients identified with alcohol use disorder when admitted to hospitals in Scotland. This statement highlights the areas of need in current services, and actions which should be prioritised.

Areas of need

Our workshop on hospital alcohol services highlighted areas of need for alcohol care teams/ alcohol treatment services in hospitals:

- Needs assessment for every acute hospital and associated catchment area to establish scale of intervention required to make a difference to hospital admissions.
- Routine alcohol screening and case identification of alcohol risk groups within each acute hospital.
- Clear and sustained funding for alcohol services.
- Joined-up working, communication, and clear treatment pathways for people with an alcohol problem.
- Multi-disciplinary and multi-agency working to better support patients with an alcohol problem.
- Clear and specific guidance, standards, and procedures for staff training and education on alcohol problems and treatment.
- Alcohol to be seen as a priority by service leaders.
- Assertive outreach/ care for people with repeated admissions for alcohol problems.
- Changes to culture, attitudes, and reduced stigma surrounding alcohol problems.

Next Steps: Priorities for Action

In order to improve alcohol treatment services, we believe that the Scottish Government should prioritise the following areas:

1. Hospital Alcohol Care Teams (ACTs) should be included as a detailed part of any future National Service Specification.
2. Standards for alcohol treatment should be created and implemented in hospitals in Scotland.
3. Patient pathways should be clear and formalised for use by local areas and initiated through the routine screening and case identification of alcohol risk groups.
4. Education bodies responsible for the training and development of healthcare professionals should provide basic education on alcohol for all disciplines.
5. Each Integration Joint Board together with Alcohol Drug Partnerships should establish a strategic group to oversee an assessment of need in relation to alcohol treatment services.

Background

What is an Alcohol Care Team?

Alcohol Care Teams are multidisciplinary teams predominantly based in acute hospitals that provide specialist care for people presenting with alcohol-related problems. It has been suggested that Alcohol Care Teams should be led by a senior clinician with identified contracted sessions to function as the "alcohol champion" within the hospital. This could be a consultant hepatologist, gastroenterologist, psychiatrist, emergency department (ED) or acute medicine physician, or nurse (Moriarty, 2019).

Alcohol Care Teams provide "*integrated alcohol treatment pathways across primary, secondary and community care, coordinated alcohol policies for emergency departments and acute medical units, a 7-day alcohol specialist nurse service, addiction and liaison psychiatry services, an alcohol assertive outreach team, and consultant hepatologists and gastroenterologists with liver disease expertise facilitate collaborative, multidisciplinary, person-centred care.*" (Moriarty, 2019, p. 294)

Evidence suggests that Alcohol Care Teams can lower the number of acute hospital admissions, readmissions, and mortality along with improving the quality and efficiency of care for those with alcohol-related health problems, leading to positive outcomes for patient health and wellbeing (Moriarty, 2019). A practical case study on ACTs conducted by the National Institute for Health and Care Excellence (NICE) reported high scores for savings, quality, and evidence of change and reported that a multi-disciplinary team could be implemented in hospitals in as little as 4-12 months (NICE, 2016).

Various studies have explored the impact of ACTs in England. For instance, a study which evaluated a model ACT found that patient length of stay was significantly reduced when consultant ward round frequency was increased. Consultants at the hospital were freed from other duties for a 2-week period of ward cover where they conducted ward rounds each day, followed by a meeting with a multi-disciplinary team. Average length of stay of in-patients dropped significantly (11.5 to 8.9 days). Mortality was also reduced from 11.2% to 6%. The hospital also saw an increase of 37% in the number of patients they saw over a 12-month period (Singh, et al., 2012). Furthermore, an Alcohol Assertive Outreach Team (AAOT) intervention was implemented at Salford Royal NHS Foundation Trust. The AAOT was a multi-disciplinary team comprised of medical, psychiatric, substance misuse, psychology, nursing, and social work specialists. The team targeted

alcohol frequent attenders (those who had the highest number of alcohol-related hospital admissions). Findings from the evaluation of the intervention reported significantly lower hospital admissions and emergency department attendances when comparing figures for before and after the AAOT was introduced. Hospital admissions dropped from 151 pre-intervention to 50 post-intervention and emergency department attendances were reduced by more than half over the 3-month evaluation period. The authors noted that the cost to implement the service would be covered by the cost reduction associated with reduced admissions and attendances (Hughes, et al., 2013). More recently, an Alcohol Care Team in Nottingham University Hospital reported the results of their first full year of operation in the media. Hospital representatives reported that they had provided advice and specialist assessments to over 2,500 people with alcohol and drug dependence. The Trust equated the success to 472 free hospital beds (BBC News, 2023).

SHAAP research on hospital alcohol services in Scotland

SHAAP commissioned Figure 8 Consultancy to conduct a review of alcohol services in acute hospitals in Scotland, with particular focus on people with Alcohol-related Liver Disease (ArLD) to identify areas that SHAAP and others may be able to support improvement. The objective of the research was to gain a better understanding of service provision for patients admitted to hospitals in Scotland with ArLD, in relation to Alcohol Use Disorder. The research was conducted using mixed methods. First, an online survey designed for physicians who treat patients with ArLD, alcohol liaison nurses and addiction nurses in acute hospitals in Scotland was carried out. Semi-structured interviews were then conducted with healthcare professionals including gastroenterologists, hepatologists, general physicians, alcohol or addiction liaison nurses, nurse specialists in hepatology and liaison and addiction psychiatrists, representing 12 of the 14 Scottish Health Boards.

Key messages from the survey responses:

- There is a disparity and lack of standardisation in screening and management of harmful, hazardous, and dependent alcohol use. The reported practices for screening in AUD patients, including those with ArLD, exhibited notable disparities.
- Inconsistencies were identified in post-discharge follow-up practices, especially regarding specialist nurses' engagement. A reliance upon community-based alcohol services for post-discharge management was noted but transition and handover arrangements were not robust, and this contributes to inadequate retention within the care system.
- Qualitative insights from survey responses revealed staffing shortages and infrastructure issues.

Key messages from qualitative interviews:

The findings from the qualitative data shine a light on the details and differences in the alcohol-related healthcare provision across Scotland and highlight:

- The gaps in policies and practices across hospitals in Scotland
- The fragmented nature of alcohol-related healthcare provision and the disparity in quality and accessibility
- The value in the development of a unified approach aimed at standardising and enhancing alcohol-related care.

Conclusions

This research into alcohol services in acute hospitals in Scotland reveals wide variation in their nature and capacity. Most hospitals have alcohol nurses to provide specialised input to in-patients identified with AUD. However, how such patients are identified is rarely systematic, the nature of the care usually includes brief interventions and a symptom-driven approach to alcohol withdrawal syndrome, and some offer specific interventions for treatment of dependence but few provide on-going AUD treatment after discharge, even for those with ArLD. There are inconsistencies in how the services are funded and, in their capacity, and a lack of clarity on leadership with wide variation in the ratio of nurses to hospital beds.

From the conclusions of this research, SHAAP identified several priorities for their future work to help improve the effectiveness of alcohol services in Scotland:

- Using the findings to help support the Scottish Government's development of a National Service Specification for Drug and Alcohol Services, which will be drawing on UK Alcohol Treatment Guidance.
- To advocate for a clear commitment from Scottish Government, Health Boards and Health and Social Care Partnership, and Integrated Joint Boards (with ADPs) to establish leadership on alcohol care in hospitals as the first step towards developing ACTs where these are not in place.
- Establishing a network of healthcare professionals working in alcohol services (and other related services) to help share information, guidance and other support.

In order to explore the appetite for a network among healthcare professionals, and to discuss the substantial issues relating to hospital alcohol services in Scotland, we hosted a workshop event in Edinburgh.

The Hospital Alcohol Services Workshop

On 30th September 2024 SHAAP, RCN Scotland and RCPsych (Addictions Faculty) hosted a workshop for those working with and in alcohol services in Scotland.

The aims of the workshop were to:

- Assess the demand for a network or other means to support clinicians and third sector partners who work in alcohol services in Scotland.
- Identify what resources or activity may be useful in supporting clinicians and alcohol care teams/ hospital alcohol services more widely.

Colin Poolman (Director of the Royal College of Nursing, Scotland), **Professor Susanna Galea-Singer** (Chair of the Addictions Faculty at the Royal College of Psychiatrists, Scotland), **Dr Peter Rice** (former Consultant Psychiatrist, NHS Tayside and SHAAP Steering Group Member), and **Professor Thomas Phillips** (Professor of Nursing in Addictions, and Director of the Centre for Addiction and Mental Health Research, University of Hull)(pictured above) presented at the event.

During the workshop, we facilitated a discussion activity to capture attendee's views. Each group was asked to reflect on six questions relating to alcohol treatment in Scotland. Afterwards, the notes taken during the activity were categorised to help extract the key messages from the discussions. The themes which were identified form the Areas of Action discussed in the next section.

Areas for Action

From the analysis of the workshop discussions, we have identified Areas for Action to improve care for people with alcohol problems.

Joined-up working, communication, and clear treatment pathways

The workshop discussions highlighted the need for improved patient pathways and a more 'joined-up' approach to alcohol care. A joined-up approach would include more connected ways of working between healthcare and other systems, helping to build relationships between and within services.

There is a need for better information sharing between services and systems (on a local practice through to national level), including practice sharing, communication between health board areas, and across sectors (e.g. third sector, GPs and hospitals, social work, homelessness services, occupational services etc). There should also be better communication to the government on the state of alcohol harms on the ground.

There was also a desire for more clarity and consistency in treatment pathways for patients experiencing problems with alcohol, including better transitions between services (from hospital to community, to discharge and following up).

Multi-disciplinary and multi-agency working

There is a need for a multi-disciplinary and multi-agency approach to alcohol care. A multi-disciplinary and multi-agency approach should include nurses (including alcohol-liaison and other nurse specialists), psychiatrists, hepatologists, senior clinicians, social workers and those from other support services (e.g. housing officers), peer support workers, and navigators.

Clear and specific guidance, standards, and/or procedures for alcohol treatment

There is a need for clear guidance and documentation for alcohol treatment which is evidence-based and, where appropriate, audited, covering, for example:

- Standards for alcohol treatment, equivalent in accountability and resource to those for MAT standards for drug treatment
- Standard operating procedures
- Clinical competencies supported by training and clinical supervision.

Clear and specific funding for alcohol services

There is a need for clear, sustained and specific funding for alcohol services in Scotland. Funding should be representative of demand to provide appropriate services including in-reach and outreach services. Funding should also account for staffing (including frontline staff), workforce and capacity planning, team development, and resourcing of the service.

Staff training/ education

There is a need for specific training and education for staff on alcohol. This should include regular training for medical school students, specialist training levels for nurses, and competence training for both speciality and wider staff. Training and education can be partly facilitated by alcohol care teams. It is essential that there is a system of supervision and support provided by appropriately skilled and competent staff. The Nursing and Midwifery Council has specific guidance for all nurses, including specific guidance for Mental Health nurses. Specific training should be delivered on:

1) the cause and effect of alcohol and mental health
2) implementing routine alcohol screening and case identification
3) understanding and managing detox and withdrawal
4) stigma
5) medication
6) case presentations.

Alcohol is supposed to be a core competency for all postgraduate specialty training (Sinclair, 2012), but this is neither tested nor enforced. Clinical competencies for care of hospitalised patients with alcohol use disorder have been defined (Phillips, 2020).

There is need to target those most likely to be readmitted within 30-days, the strongest predictors being those with increasing comorbid conditions, homeless and individuals who previously requested discharge against medical advice (Coleman et al, 2023; Phillips et al, 2025).

Alcohol to be seen as a priority

There is a need for alcohol patients and services to be seen, and treated, as a priority by national policymakers and local service leaders. There is also a need for parity of consideration for alcohol and drugs, and for alcohol to be viewed separately to drugs.

Stigma and change in culture

Focus should be placed on reducing stigma to enable people to make the first step in asking for help. There is also a need to focus on the relationship between stigma and lack of engagement in alcohol services. Cultural change is needed, as is increased public awareness, focusing nationally on how alcohol is normalised and its cost to society. Stigma amongst healthcare professionals should be addressed by targeted training on stigma. Staff should also receive training on different models of care for alcohol treatment.

Assertive outreach/ care

There is a need for assertive outreach in relation to alcohol services for those patients with severe alcohol dependence who are frequent hospital and A&E attenders. Assertive outreach was mentioned frequently during the workshop discussions, particularly in the relation to the role of ACTs in Scotland and in supporting transition into community services.

There is emerging evidence from the NIHR Mental Health Implementation Network demonstrating cost savings on hospitalisations (due to alcohol assertive outreach), from studies in London, Hull and Manchester (Mills, Case, Hermann & Phillips, 2025).

Alcohol Death Reviews

An analysis of publicly available Alcohol Death Reviews undertaken by ADPs (Alcohol Focus Scotland, to be published 2025) found that there is a relationship between hospital presentations and time to death.

- One audit found each person attended an ED 8 times on average over 6 years
- Another found 88.4% of patients who died from an alcohol-related cause were admitted to hospital in the last three years of life, with an average of 3.9 admissions per person, with many having 10 or more admissions
- Another found 95% of patients had attended ED in the last three years of life with four admissions per person
- 19% of ED attendances in one review were in the final 180 days of life
- Services most regularly accessed in hospital in one review were general medicine, general surgery, gastroenterology, orthopaedics and respiratory medicine with reasons ranging from head and other injuries, feeling unwell, alcoholic liver disease, alcohol seizures, fractures, withdrawals and falls.

Next Steps: Priorities for Action

The Scottish Government should consider the following options when considering how to implement a comprehensive approach to alcohol treatment services in acute hospitals in Scotland:

1. Alcohol Care Teams (ACTs) should be included as a detailed part of the proposed National Service Specification.	This should include details on the structure, role, staffing and evaluation of ACTs. Particular attention should also be given to transition between services. We recommend a 'warm handover' – including community services engaging with the patient prior to discharge and following up promptly on discharge (within 48 hours). We also recommend routine screening which is automated so that ACTs can see those with alcohol dependence within 24 hours of admission to allow an appropriate drug regimen to be administered to help stabilise patient. As part of the National Service Specification standardised care should be built around fundamental pillars such as: • transitions between services • specialist training for ACT staff • screening, identification and appropriate pathways • use of data to inform service provision
2. Standards for alcohol treatment services in acute hospitals should be created and implemented.	This could include the adaption of the Alcohol Care Team Innovation and Optimisation Network (ACTION) standards for ACTs in England, for use in Scotland, or another evidence-based approach.
3. Patient pathways should be clear and formalised for use for local areas.	These should be integrated between services and systems and should respond flexibly to the needs of each individual patient.
4. Education bodies responsible for the training and development of healthcare professionals should provide basic education on alcohol.	Education bodies responsible for the training and development of healthcare professionals should provide basic education on alcohol including presentations, managing detox and withdrawal, medication, the relationship between alcohol and mental health, and stigma.
5. Each Integration Joint Board together with Alcohol Drug Partnerships should establish a strategic group to oversee needs assessment.	Each IJB should collaborate with ADP to establish a strategic group to oversee a needs assessment of alcohol services and then work incrementally to respond to the identified (and growing) need within acute hospitals, ensuring people are transitioned to specialist community services without falling through gaps.

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