From the Editor

MCA AGM November 2016

The 2016 MCA AGM took place on November 14th at the Royal College of Surgeons in London, chaired by vice-president Bruce Ritson.

Dr Dominique Florin

Editor

MCA treasurer Graham Warner updated members regarding the MCA’s financial situation. Despite still running a deficit, Mr Warner reported that the MCA remained in a healthy financial position. As previously, the major sources of income continue to be the Journal profit share and the investment income from the sale of the Journal. Nevertheless, the on-going long-term challenge remains to establish a balance in the MCA finances. Mr Warner was of the view that further cost-cutting in the MCA office would be difficult without severely curtailing activities and that the best option for improving our financial position would be to explore income generating activities or more fundamental change such as an organisational merger.

The year’s activities were then reviewed by MCA Medical Director Dominique Florin. Dr Florin drew attention to the challenges facing the MCA. In addition to the financial challenges described by Mr Warner, there are also the challenges of being a small organisation with a national remit in the current NHS environment. Dr Florin highlighted the difficulties of pursuing an educational agenda in the face of re-organisations which have lessened educational budgets and opportunities. Despite this, the Journal has continued to flourish and the MCA has made increasing use of digital and social media opportunities.

In the final part of the AGM MCA Chairman Professor Colin Drummond reviewed the broader policy context in which the MCA operates. Despite a number of challenges such as the NHS reorganisation, the loss of training posts and the continued high levels of alcohol consumption, there were also some positive aspects. A particular mention was made by Professor Drummond of the new report from PHE on the public health burden of alcohol and the evidence for the effectiveness and cost-effectiveness of alcohol control policies. This is an impressively comprehensive document which will be of interest to all working in the field. It can be accessed at https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

In this issue

I am delighted in this issue to publish papers from two of the excellent speakers at last year’s Symposium. Eileen Kaner gives a typically intelligent and nuanced account of the effectiveness of brief intervention for alcohol. In the second paper, Andrea Williamson, a GP and academic, gives an inspirational account of a concerted effort directed at some of the most disadvantaged members of our society. One of the key features I believe is that this project has lasted 7 years. It is a sad reflection that some many excellent ideas in the health service fail simply because of a lack of continued funding or because re-organisation supersedes.

The year ahead

This year is the 50th Anniversary of the MCA. To mark this occasion the MCA will be holding a series of events (please see page 7 for more information).

Nurses event

For the first time in its history, the MCA is holding an event specifically for nurses, in response to the increasing demand from nurses for an event aimed at issues that they face as healthcare professionals. This event will take place on 12th September 2017 in central London. It will present material for all nurses to improve the care they offer to patients with alcohol-related problems. Please keep an eye on our website for more information.
Images from our 2016 Symposium: Alcohol and Health harm; what can doctors, nurses and other professionals do?

A: Dr Iain Smith opening the symposium / B: Max Glatt award winner Professor Jonathan Chick receiving his award from MCA Chairman Professor CColin Drummond / C: Mark Bellis 'The Alcohol Harm Paradox, life course effects and harms caused to others - Measuring hidden costs of a poorly regulated alcohol industry' / D: MCA Regional Advisors Meeting / E & F: Exhibitors.
G: MCA Annual General Meeting / H: Nurses lunchtime session led by Diane Goslar with Adrian Juggdoyal / I & J: Student competition award winners: Conor Walsh (Imperial College London) and Michael Zihao Tai (Oxford University) / K: MCA team working hard manning the stand! / L: Dr Peter Rice closing the symposium

All powerpoint presentations and videos from the day are now all available via the MCA website:

Powerpoints http://www.m-c-a.org.uk/events/symposium_presentations
Videos http://www.m-c-a.org.uk/gallery/video/list_album_videos?id=6
The power of prevention in tackling alcohol health harm – can we dovetail the differing priorities of Public Health and Primary Care?

Professor Eileen F. S. Kaner – University of Newcastle upon Tyne

Excessive drinking is a significant cause of mortality, morbidity and social problems in developed and in developing countries.

This presentation focused on preventive care that can be delivered by practitioners and, in particular, brief alcohol interventions in primary health care settings. Brief interventions aim to reduce alcohol consumption and related harm in heavy drinkers who are not seeking help for alcohol problems. They usually comprise a conversation between a patient, who has been screened and identified as a heavy drinker, and a primary care provider who typically delivers: feedback on the person’s alcohol use and potential harms, benefits of reducing intake, structured advice on how to reduce drinking, and the development of a personal plan to reduce consumption. A rigorous review of the effectiveness of brief interventions in primary care settings was completed in 2007 [1], and this talk summarised the findings of a recent Cochrane Collaboration review update of this evidence.

The new review included 69 trials encompassing 35,642 patients. Most trials were based in general practice (55%) as opposed to emergency care (39%), and typically compared brief intervention to controls consisting of assessment only, treatment as usual or a minimal health or alcohol advice. The mean baseline alcohol consumption was 183gms per week in newer trials (23 standard UK units) compared to 285 gms per week in the previous review (37 standard UK units), which was a considerable drop in the definition of heavy drinking. The primary meta-analysis of 34 trials (15,197 participants) provided moderate quality evidence that participants receiving a brief intervention consumed less alcohol than controls after one year (mean difference: -20 gms per week, 95% CI: -28 to -12). This effect size was smaller compared to the 2007 finding when it was -38 gms per week (95% CI: -54 to -23) at one year. As in earlier work, there was no evidence that extended intervention had a significantly greater impact than brief intervention on reported drinking levels (mean difference = 2 gms per week, 95% CI: -42 to 45). Interestingly, the impact of brief alcohol intervention in the 25 general practice based trials (8811 patients) was -26 gms per week (95% CI: -37 to -14) and this was greater than its impact in the 10 emergency care trials (n=6386 patients) which was -10 gms per week (95% CI: -17 to -7). Thus brief interventions are beneficial albeit with a modest effect size, although this is greater in general practice compared to emergency care settings. Nevertheless, the combination of reduced baseline drinking levels and an increase in the content of control conditions (16 trials included a control group with some alcohol advice content) may account for the smaller effect of brief interventions since 2007. This raises the question of whether trials in the brief alcohol intervention field may now be focusing on people whose consumption levels are too low to make a clearly discernible difference.

Whilst small effects can be meaningful at a population level, they are challenging for primary care practitioners who are worried about their very limited time available to deliver preventive advice as well as possible negative patient reactions. These reasons are likely to explain why implementation of screening and brief alcohol interventions occurs at a relatively low level in routine primary care practice [2]. Data from the Toolkit study, a monthly population survey of 1500 adults in England, were presented to provide details about general household population views about alcohol [3]. In repeated survey findings (summarised every month), rates of heavy drinking ranged between 15 and 25% of respondents. In addition, many heavy drinkers reported being motivated to cut down on their drinking at key times in the year (around 30%), or that they have tried to do so at some point in the past year (around 20%). However, just 5-6% of these people report receiving any advice or support from GPs or nurses about their alcohol consumption or what they can do to help reduce drinking to lower risk levels. Thus a challenge for the field is how to support patients who might value alcohol advice to help them reduce their heavy drinking behaviour whilst not over burdening busy practitioners with many other priorities and calls upon their time.

The presentation ended with details of a recently completed Cochrane Collaboration review on the effectiveness of digital alcohol interventions at helping people reduce their drinking [4]. This review identified 55 trials (n=33,899 participants) which compared the drinking of people receiving information and/or advice about their alcohol consumption from computers, telephones or internet sites against those that did not (usually screening only controls). There were 40 trials in the primary meta-analysis (including 19026 participants) and this found that those receiving a digital intervention drank 24 gms less per week (95% CI: -16 to -31) compared to controls (an effect size of 3 standard UK units) than controls (figure 2). This finding was reported at the longest follow-up point which ranges from one month to a year. Moreover, the effect of the digital intervention was no longer statistically significant by 12 months. Thus despite seemingly similar effect sizes at first glance, practitioner delivered advice is likely to have a more sustained effect. Nevertheless, digital interventions may be a helpful adjunct to practitioner input, particularly for patients who rarely visit a doctor or nurse.

This said, the impact of digital interventions is only likely to be realized if people (that is potential users) feel the advice is easy to access, interesting and relevant to them. Thus a second review focused on investigating the views of people who had used digital alcohol interventions, especially regarding their acceptability and also features of the programmes that encouraged engagement with them [5]. Fourteen studies explored people’s views about how well they could use and understand alcohol-related advice delivered by computers, mobile telephones or the internet. Overall views were positive, although use of technology to access advice about alcohol depended on three linked features. 1. How easy the technology is to use and understand and how attractive it is – there was a preference for uncluttered screens, colourful content and the ability to easily check in regularly or be sent reminders; 2. The type of advice being delivered – many reported finding it useful (and sometimes surprising) to get feedback on how much they drank, and they liked a friendly feel to messages rather than a ‘telling off’; and 3. Content
that fits with peoples’ daily lives or values - some users felt they would prefer to talk to a doctor about alcohol and felt this helped them keep track of their drinking, whilst others liked the anonymity of technology and felt this helped them to be more honest about their drinking. Thus digital alcohol interventions have the potential to be a helpful addition to brief interventions delivered in primary care (or an alternative for some people), if patients are able to be directed to evidence-based and well-designed programmes.

References

Primary care support for problem alcohol use in areas of highest deprivation

Dr Andrea E Williamson GP and Clinical Senior University Teacher

I have a clear memory of sitting many years ago now- in a rather ranky (that’s a Scots word for dirty) consulting room in one of the old Glasgow hostels having just had another unsatisfying and mystifying consultation with a patient. What I thought I had learnt about how patients engage in care just did not make sense when trying to work with patients in this setting. Grappling with this has continued in the various roles I have- research, addictions and general practice. I tend to think about it in two ways- what skill set do we need as health professionals to increase engagement in care and how does the health care system need to change to foster this too?

GPs at the Deep End

The GPs at the Deep End project was set up 7 years ago driven by a realisation that General Practice (and wider health care) delivery was just not working in areas of high socio-economic deprivation. It is a voluntary collective of both service and academic GPs who meet regularly.

Using Scottish Index of Multiple Deprivation (SIMD) scoring the Deep End project includes the 100 most SE deprived practices in Scotland-76 of those are in Glasgow. The majority of people living in Deep End practice areas experience high socio-economic deprivation- so called blanket deprivation. The evidence tells us that people living in deep end areas experience complex co-morbidity and premature mortality.

This graph from a recent paper by Deep End colleagues illustrates this:

![Graph showing standardised mortality rates and consultations](Source: Figure 1 McLean et al BJGP e799, Dec 2015)

It’s this reality of how much unmet need is NOT met by health care provision that was the inspiration behind the Deep End name and logo.

Deep End Themes

The most important focus of our work has been addressing the Inverse Care Law just described and illustrated. Linked to that is how people’s complex health and social care needs can be met more effectively.

This includes more GP time to see patients, better links within primary care and between primary and secondary care. A key focus is improving patient engagement in care. This is a pervasive theme across the Deep End- so not just in clinical settings like addictions.

We would not be taking account of the evidence base and our role as patient advocate curiously if we did not also pay proper attention to the wider social determinants of health outside of health care delivery.
Primary care support for problem alcohol use in areas of highest deprivation continued...

Deep End activities

So we have been listening to what GPs working in Deep End practices have to say, this has produced 30 reports so far[4].

We have provided input to local and national strategy development across primary care, mental health and social security including engaging with civil servants and politicians. It’s been a steep learning curve and sometimes uncomfortable - however we have been listened to, and we think we are making a difference. Key to that has been the skills and resources that each of us have brought and the mutual support. We have even had our model of getting active replicated in North East England, Ireland and Australia!

Theoretical perspectives

Some important theoretical perspectives have shaped our thinking about how we deliver care. Most importantly when considering mental wellbeing and problem substance use- but as generalists they pervade all that we do, because in the Deep End physical and mental co-morbidity are so intertwined.

We know that adversity in childhood and across the life course are important determinants of health. This is in terms of outcomes as evidenced by epidemiological work on Adverse Childhood Experiences linked to a range of physical mental illness and ‘health harming behaviours’[5]. Also the factors that lead to a ‘good enough’ childhood or a ‘toxic’ constellation of experiences and lack of key supports[6], including the attachment style people develop that lead to negative outcomes. Also importantly is the role that cumulative negative life experiences that manifest as complex (type 2) trauma in adult hood[7]. Working in a trauma informed way particular relevance for us as health professionals because it provides tools for working with patients in health care settings[8].

So why are these theories relevant when thinking about the Deep End GP setting and more specifically working effectively with patients with problem alcohol use?

One potential way to look at ‘health harming behaviours’ is to consider whether low service engagement might be a component of this. A big data and linkage project looking at Serial Missed Appointments in the Scottish NHS is currently underway[9] starting to test this out.

These theories also put relationship function at the core of how we think about consultations and health service design. Low trust in care and high impulsivity are important features. More implicit than explicit in most of these theories is that problem substance use for most people in the Deep End is about escape coping from distressing feelings or memories.

So approaching our work from these theoretical perspectives means that we understand the majority of people we work with are adapting to coping with feeling unsafe and insecure and this has relevance for how our services should respond.

Deep End Attached Alcohol Nurse Pilot

This pilot in North West Glasgow was set up between GPs at the Deep End, NHS Glasgow and Clyde Addiction Services and funded by the Alcohol Drug Partnership. Unfortunately the pilot only ran for a year (July 2015-16) and formal evaluation was not embedded in it.

Six Deep End practices identified by addiction services were offered (and all accepted) this service. Two full time, band 6, experienced, specialist alcohol nurses were attached to the practices and line managed by the nurses team leader from the local community addiction team. A lead GP from each practice was paid one locum session per month so that they had an element of protected time to liaise with the nurses and take part in quarterly team meetings. The nurses provided what would be considered usual care in the context of the alcohol teams in Glasgow- with some important differences. Ninety five out of a hundred and thirty two patients received an assessment or care from the attached alcohol nurses (AAN). What brought us up short as the pilot neared its end was the publication of an in-depth report about alcohol related deaths in Glasgow[10]. There were striking similarities between the profiles of patients who died and the patients who were cared for in the pilot.

Theory of change

So with a short timescale and limited data what did we think was different about the pilot? This is the theory of change that the whole project team thought was important.

There was a general sense that patients felt there was reduced stigma by being offered support in their GP setting with no need to visit the community addiction team.

The focus on engagement was the core component of the theory of change this and was in 3 areas.

1. Responsiveness- patients were seen quickly—the average was 5 days from the referral being received.

2. ‘Stickability’ (a phrase used in settings like homelessness where professionals stick to patients no matter where they go)- of the 13 patients who required more than one contact the majority needed only that. A small number required many more before effective engagement was achieved. Sixteen patients were referred more than once by GPs during the year.

3. Flexibility- very quickly this pilot became a home visiting service with 96% of contacts taking place in the patients’ home.

A vital component of the service was the team working relationship and function that built up between the GP practice and the attached nurses. Clinical recording was in the GP records so GPs knew what was happening with complex patients in crisis and the nurses received positive support from GPs.

Conclusion

This pilot has demonstrated that effective collaboration between specialist services targeted at high prevalence general practice settings is welcomed by GPs.

Our theory of change would certainly reinforce our thinking that engagement strategies are key in Deep End settings and also that clinical recording and communication is vital.

References


The MCA came into existence on the 20th of April 1967 when 50 founder members met at the BMA to elect officers and discuss future policy. Sir Clement Price Thomas (surgeon) was the first chair of the organisation. In his opening speech he felt “there had been ample evidence of an urgent need for a representative medical body to concern itself with the problems of alcoholism”.

The MCA founder members were doctors from all specialities including pathology, psychology, general practice and pharmacology. Since that date the MCA has developed as an educational charity for doctors, medical students and other healthcare professionals.

The MCA journal ‘Alcohol and Alcoholism’ was launched in 1983 by Dr Allan Thomson, Dr Spencer Madden and Dr Abdulla Badaway. The journal is the official journal of both the MCA and ESBRA.

In 2017 the MCA are holding the following events in celebration:

14th November: Witness event on 50 years of the MCA at BMA House, London 1pm – 4pm
http://www.m-c-a.org.uk/events/2017_witness_seminar
Please contact Clare for further information or to book this event info@m-c-a.org.uk

14th November: 50th Anniversary Dinner at the Beaumont Hotel London, Mayfair 7.30pm
http://www.m-c-a.org.uk/events/50th_anniversary_dinner

15th November: 2017 Symposium on Alcohol & Medicine; Past, Present & Future at BMA House
http://www.m-c-a.org.uk/events/2017_symposium
Please contact Emma for further information or to book this event Emma.darcey@m-c-a.org.uk
2016-17 Legacy Essay Competition

Do the new UK Government guidelines for alcohol take gender equality too far?

In 2016 the UK government announced new weekly recommended maximum alcohol intake guidelines. The recommendations for males have been lowered so that for the first time they are the same for males and females. In the light of differences between male and female patterns of drinking and physiology, is this a sound recommendation or has gender equality been taken too far?

Closing date: 3rd April 2017

To enter please submit your 3,000 essay to info@m-c-a.org.uk (Vancouver referencing style (references and title not included in word count).

*Entrants must be current medical students in the United Kingdom.

The winning essays will receive:

1st Place £500
2nd Place £300
3rd Place £200

And all winners will be invited to attend the 2017 AGM and CPD approved seminar and be awarded a signed certificate.

The winning essay will also be published in the MCA annual report.

Latest ‘Alcohol & Alcoholism’ Journal News

Does Industry-Driven Alcohol Marketing Influence Adolescent Drinking Behaviour? A Systematic Review, Stephanie Scott, Colin Muirhead, Janet Shucksmith, Rachel Tyrrell, and Eileen Kaner

http://alcalc.oxfordjournals.org/content/early/2016/11/17/alcalc.agw085.full?papetoc

The Association Between Health Changes and Cessation of Alcohol Consumption, Ji-Eun Park, Yeonhee Ryu, and Sung-Il Cho

http://alcalc.oxfordjournals.org/content/alcalc/early/2016/12/03/alcalc.agw089.full.pdf?papetoc=

Internet Support for Dealing with Problematic Alcohol Use: A Survey of the Soberistas Online Community, Julia M. A. Sinclair, Sophia E. Chambers, and Christopher C. Manson


Call for Regional Advisors

The MCA has a network of Regional Advisors across the country. The RA’s are academics and clinicians linked to the medical schools in their area and are a vital part of the MCA remit to ensure good education of alcohol related issues to students.

At present the MCA is looking for RA’s for the following areas:

East Anglia
Leeds
Leicester
London (Kings College Hospital)
London (St George’s Hospital)

If you would like to know more about the role please contact the Medical Director via email: Dominique.Florin@m-c-a.org.uk

(You do not have to be an MCA member to volunteer for this role)