The Role of the Alcohol Outreach Nurse & it’s challenges

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The Queens Nursing Institute 19/10/2016
Who are Brownlow Health?

- A busy Liverpool City Centre GP Surgery
- 4 sites – inclusive of those supporting students
- 36,000 patients
- Has specific remit to work with homeless
- 700+ patients registered that are homeless

(Homeless patients represent less than 1% of the patient population of Practice and 25% of admissions)
Service delivery

• Has dedicated outreach Nurses
  - Homelessness nurses Ian Harrison & Melanie Johnson
  - Alcohol Outreach Nurse*
  - Wider GP lead team with dedicated GP partner for Homelessness
- *Expert supervision accessible via Alcohol Nurse Consultant (RLUH)
Why have an Alcohol Outreach Nurse?

- The role was designed to work with those patients registered in the City Centre Neighbourhood who had problematic Alcohol Use and were frequently attending hospital.
- This was expected to be largely made up of the Homeless Community and Students.
- The role is proactive & reactive.
- Patients being made aware of role by direct contact, or via colleagues within the Surgery.
Aim?

- To work with those who are frequently attending A&E
- To encourage contact with GP surgery / appropriate access to treatments
- To act as link between other agents for complex cases
- To be point of contact for those who are unlikely / choose not to engage with community based alcohol services
So what is the problem with Alcohol?
It’s been around for a long time……..

- In 2004, publication of analysis of organic materials absorbed into pottery jars from the early Neolithic village of Jiahu in Henan Provence, China found evidence of a mixed fermented beverage made from rice, honey and fruit (hawthorn berry or grape).
- The pottery was estimated to date from around 6,000-7,000 BC.
and today.....
• The total annual cost to society of alcohol-related harm is estimated to be £21bn.
• The NHS incurs £3.5bn a year in costs related to alcohol.
• Few other health harms have such high overall costs when the impact on productivity and crime are included.

(PHE, 14 Oct 2014)
So why should we watch our BAC?

• There were an estimated 1.09 million hospital admissions in 2014/15, where alcohol-related disease, injury or condition was the primary reason or a secondary diagnosis
  
  (1.06 million in 2013-14)

• There are over 60 medical conditions, including mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver and depression
• Hospital visits for alcohol poisoning have doubled in six years, with the highest rate among females aged 15 to 19, a report has found.
• Emergency admissions due to the effects of alcohol, such as liver disease, have also risen by more than 50% in nine years to 250,000 a year in England.
• Rates were highest in deprived areas and in the north, and among men aged 45-64

(Nuffield Trust, 2015)
http://www.bbc.co.uk/news/health-35151246
• The North West has the highest number of alcohol related deaths in England
• A person is admitted to hospital every four minutes in the North West because of alcohol
• In the North West, 1 in 5 adults drink at a level likely to pose significant risk to health

Top 5 alcohol related deaths by causes and age group, England and Wales, 2012

Source: Office for National Statistics
And homelessness.....

92%
520 different households contacted the Housing Options Service

8%
44 different people seen Sleeping Rough

(Liverpool City Council homelessness forum September 2016)
Health and Homelessness – why it matters?

- On average, homeless people die at 47 years old; 30 years before the national average (men 47yrs; women 43yrs)
- In a survey, 70% of homeless population had physical health problems
- 13 times more likely to be a victim of violence
- 70% of clients in homelessness services in England have mental health needs
- Being homeless itself is traumatic - detrimental effects on physical and mental wellbeing
- Difficulties for homeless people accessing primary healthcare services
- Significant use of emergency services

(Liverpool City Council homelessness forum September 2016)
Sensible drinking is defined by the NHS as 'drinking in a way that is unlikely to cause yourself or others significant risk of harm.'

The NHS recommended sensible drinking levels are:

- **Men & Women = 2 to 3 units per day.**

Whether male or female you should try to have at least two alcohol free days each week to give your liver a break from alcohol, especially if you have had a heavy drinking session the night before.

(14 units weekly for men & women)
**Litres Principle:**

The unit amount per litre is the same as the `abv %` of the drink (UK)

One litre of 4% abv beer = 4 units

One litre of 7.5% abv alcohol drink = 7.5 units

One litre of 40% abv alcohol drink = 40 units.

(Beer cans often 500mls – so ½ litre. Wine bottles are commonly ¾ litre – so take quarter off.)
### Risk Levels and Common Effects

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<tr>
<th>Risk</th>
<th>Men</th>
<th>Women</th>
<th>Common Effects</th>
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| **Lower Risk**| Both men and women should not regularly drink more than 14 units per week spread over three or more days | • Increased relaxation  
• Sociability  
• Sensory enjoyment of alcoholic drinks |                                                                     |
| **Increasing Risk** | Regularly drinking 15-50 units per week | Regularly drinking 15-35 units per week | **Progressively increasing risk of:**  
• Low energy  
• Relationship problems  
• Depression  
• Insomnia  
• Impotence  
• Injury  
• High blood pressure  
• Alcohol dependence  
• Liver disease  
• Breast, mouth and throat cancers | |
| **Higher Risk** | More than 8 units per day on a regular basis or more than 50 units per week | More than 6 units per day on a regular basis or more than 35 units per week |                                                                     |
What’s your personal target?

Making your plan

- Have several ’drink-free’ days, when you don’t drink at all
- When you do drink, set yourself a limit and stick to it
- Quench your thirst with non-alcohol drinks before and in-between alcoholic drinks
- Avoid drinking in rounds or in large groups
- Eat when you drink - have your first drink after starting to eat
- Switch to lower alcohol beer/lager
- Avoid going to the pub after work
- Plan activities and tasks at those times you would usually drink
- When bored or stressed do something physical instead of drinking
- Avoid or limit the time spent with “heavy” drinking friends

Psychological/Social/Financial

- Improved mood
- Improved relationships
- More time for hobbies and interests
- Reduced risks of drink driving
- Save money

Physical

- Sleep better
- More energy
- Lose weight
- Reduced risk of injury
- Improved memory
- Better physical shape
- Reduced risk of high blood pressure
- Reduced risk of cancer
- Reduced risks of liver disease
- Reduced risks of brain damage

There is no completely safe level of drinking, but by sticking within these guidelines, you can lower your risk of harming your health:

- Adults are advised not to regularly drink more than 14 units a week
- If you do drink as much as 14 units in a week, spread this out evenly over 3 or more days.

What targets should you aim for?

What’s everyone else like?

The potential benefits of cutting down

Source: Health Survey for England 2013

Download this alcohol advice tool from http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/
Health risks......
There are three main direct mechanisms of harm caused by alcohol consumption in an individual (Babor et al., 2003; WHO, 2004b; WHO, 2007).

These three mechanisms are:

• toxic effects on organs and tissues;
• intoxication, leading to impairment of physical coordination, consciousness, cognition,
• perception, affect or behaviour;
• dependence, whereby the drinker’s self-control over his or her drinking behaviour is impaired.
Features of alcohol dependence

Tolerance – a need to drink/use more to get the same effect or less effects with the same amount

• The brain adjusting to function in the presence of alcohol.
• If the intake of alcohol is stopped, the blood-alcohol level decreases but the brain remains in a hyperexcited state, which leads to the withdrawal syndrome.
• Needing to ‘relief drink’ on waking to avoid withdrawal
• Psychological withdrawal symptoms can include:
  - anxiety
  - depression
  - irritability
  - restlessness
  - insomnia

• Physical symptoms can include:
  - hand tremors /body shakes/ flaps
  - sweating
  - nausea

Complicated withdrawals can also include features of hallucinations and fits/ seizure.

• Severe and untreated alcohol withdrawal can be fatal
Alcohol, nutrition and calories...

- There are 7 kcal in each gram of alcohol
- This is almost the same as in a gram of fat
- There’s no nutrients in alcohol drinks
- Alcohol calories are often referred to as ‘empty calories’.

(British Nutrition Foundation, 2014)
Calories in a bottle of wine...

• A bottle of white wine can contain between 490 – 635 calories
• Generally the stronger the %abv – the more calories
and with beer....... 

- Standard larger 3.5%abv (500ml can) = 160 calories (1.75units)
- Premium 5% abv (500ml can) = 205 calories (2.5units)
- Super strength 9% abv (500ml can) = 345 calories (4.5units)
and white cider....

- 22.5 units in a 3 litre bottle of 7.5% abv cider
- +/- 1077 calories a bottle!
+/- same as 4 slices of chocolate fudge cake
- Same as 4 slices of a large BBQ stuffed crust pizza
Why does vitamin depletion happen?

- People who drink heavily over long periods of time often have lowered vitamin levels (especially thiamine)

  - This can be because of:
    - poor eating habits
    - poor appetite
    - vomiting
    - damage to the stomach lining (affecting the ability to absorb vitamins)
    - malabsorption because liver less able to produce bile to aid digestion
    - when the liver is damaged by alcohol, it is less able to process vitamins to make them bioavailable (including thiamine)
Why is thiamine important?

• Thiamine (vitamin B1) is an important nutrient for taking energy from food and turning it into energy for our brains, nerves and heart.

• It is needed in order to process carbohydrates, fats and proteins.

• Thiamine deficiency may be called Wernicke’s encephalopathy or Beriberi, depending on how it presents.
High index suspicion of thiamine deficiency should include:

• Significantly underweight patients including those with a low BMI (but not always)
• Vomiting
• Ataxia
• Memory Problems
• Clinical signs of malnourishment
Thiamine Deficiency over time:

Cellular Damage
Thiamine-dependent cellular systems begin to fail leading to a decrease in enzyme activity

- Neuronal necrosis
  - Drop in energy production leads to neuronal damage and cell death

-Metabolic impairment
  - Lack of thiamine-dependent enzymes alters cerebral energy utilisation

(Adapted from Sechi and Serra 2007)

This means that brain damage can occur as a result of alcohol use, that does not resolve once withdrawal management is completed.
So what is alcohol related brain injury (ARBI)

• an umbrella term for the damage that can happen to the brain as a result of long-term heavy drinking. Over time, drinking too much alcohol can change the way the brain works and its physical shape and structure.

• Serious consequences can include
  • - personality changes
  • - problems with thinking
  • - problems with mood
  • - problems with memory
  • - problems with new learning
Key points for conditions ranging from Wernicke’s Encephalopathy (WE); Alcohol Related Brain Injury (ARBI) and Korsakoff’s syndrome

- **Cerebellar Atrophy** – primarily affecting coordination and causing a wide-based gait
- **Peripheral Neuropathy** – leading to reduced sensation in feet and legs (and sometimes the hands)
- **Hepatic Encephalopathy** – severe alcohol related liver disease can cause an acute disturbance of brain function with confusion initially but may develop to coma
- **Frontal Lobe Dysfunction** – this part of the brain is important for our ability to plan and organise, judgment, problem solving, be flexible in thinking and behave in socially appropriate ways
- **Wernicke’s Encephalopathy** – caused by a lack of thiamine (Vitamin B1) and which causes confusion, ataxia and disturbance of the muscles controlling the eye movements.
- **Korsakoff’s Amnesic Syndrome** – leading to difficulty in learning new information, memory loss and confabulation

(Taken from Assessment of Incidences of Alcohol-Related Brain Injury (ARBI), HSE West, 2011)
The recovery outcome for people with ARBI is thought to be split into quarters (Smith and Hillman, 1999)

• 25% making a complete recovery
• 25% making a significant recovery
• 25% making a slight recovery
• 25% making no recovery.

• It should be held in mind that the circumstances for these outcomes are that patients had stopped using alcohol.
Why does this happen?

The reasons can be varied and could include:

• Alcohol is a toxin; long term this can damage brain cells
• Alcohol is a diuretic. This can lead to dehydration which can affect brain cells (shrinkage / cell death)
• Vitamin deficiency
• Alcohol related cardiovascular changes can increase the risk of heart attack / arrhythmia and strokes (which can affect the brain)
• Intoxication can lead to increase risks of falls/ fights and vulnerability to attack (head injury)
• Alcohol withdrawal can be taxing to the brain and nervous system (form of neurogenic shock)

(Alcohol Concern 2016)
Options for treatment....

- Working to engage
- Ensure understand risks of abrupt alcohol cessation
- Thiamine prescribing
- Alcohol reduction plans
- Detox

- When there are delays with access to detox or resistance to this option
  - Ensure compliance with thiamine / diet / fluids
  - Consider I.M. high potency vitamins (Pabrinex®)
At Brownlow we have a ‘Pabrinex®’ Protocol for use outside of detox (I.M)

- Where there is evidence of poor compliance with oral medication
  - Where there is high risk of Wernicke’s encephalopathy with withdrawal
  - Where there is evidence of poor nutrition / weight loss / neglect
  - Evidence of alcohol related ataxia / peripheral neuropathy / memory concerns (MoCA*)

(protocol was co-authored with Alcohol Nurse Consultant Dr Lynn Owens)

* Montreal Cognitive Assessment
Working closely with specialist alcohol service colleagues in the community

• Liaison with Specialist Alcohol Nurses within Royal Liverpool Hospital
• Good links with community based alcohol service (Liverpool Community Alcohol Service – LCAS)
• Good relationship with local inpatient detox providers (Mersey Care)
  - able to complete detox assessment for this service with hard to reach individuals in the community
  - assessments are then dealt with directly in Service’s ‘Gateway Meetings’
Linking in with other support

• Close working with Social Workers within our ‘Integrated Social Care Team’
• Local rehabilitation Service referrals
  - Park View Project
  - Transforming Choice
• Referrals for allocation of dedicated intensive support worker via the Liverpool Waves of Hope project
• Working with local recovery community agencies
  - A-PASS
  - The Brink
  - Crisis Merseyside
  - Whitechapel Centre and Basement projects
and accommodation…..

• Need for housing contingency plans to be in place pre-detox
• Some hostel housing providers prefer that people do not return post detox, as feel risk of relapse too high*
• Pressure on individual by associates
• *May find prospect of looking for accommodation ‘overwhelming’

Support and ‘linking in’ with local agencies essential
And what about relapse avoidance?

- Working to plan aftercare before detox
- Discussing options for anti-craving prescribing
  - Acamprosate
  - baclofen
  - referral for Nalmefene therapy
- Activity options

Keeping regular contact via drop in service
Maintaining contact with outreach if necessary
Access to local recovery community
Keep contact with homelessness providers
Case study 1

• John is from Eastern Europe. Speaks Polish with his associates. Cannot speak English. No recourse to funding. In late 40’s
• Alcohol dependent at first contact
• Difficulty with inguinal hernia and felt unable to seek work given pain and discomfort from this
• Vulnerable to assault whilst sleeping rough
• Referred by GP for hernia repair and close linking in with colleagues at Whitechapel Centre who were able to organise funding for temporary accommodation post–op.
• Able to link in with Specialist Alcohol Nurse Team at Royal Liverpool Hospital
• Able to co-ordinate community detox post-op whilst in temporary accommodation
case 1 contd...

• Able to start anti-craving prescribing on completion of detox

Period of instability following end of funding for accommodation post –op. Property and medication stolen whilst sleeping rough and assaulted. Relapsed

• Was able to decide wanted to return to being alcohol free
• Drink reduction advice / plan (successful)
• Able to re-start anti-craving medication when alcohol free
• Continues to be supported with anti-craving therapy & currently remains alcohol free
• Living in City Mission
• Attending ESOL classes
Case study 2

• Michael chaotic drug and alcohol user, early 30’s and living in hostel
• Assaulted near his hostel and sustained serious head injury
• Prolonged hospital inpatient stay and alcohol free when discharged back to community (to his hostel)
• Relapsed whilst back at hostel

• Requested access to detox. Able to discuss local options together with working to support alcohol reduction plan
• Poor attender at GP surgery and felt wouldn’t work with statutory alcohol services (previous negative experiences)
• Able to link in with local ‘Social Detox’ project and did attend GP surgery to confirm plans
• Able to start anti-craving medication when alcohol free and remained at project for period of rehabilitation
case study 2 contd.....

- Currently living independently
- Has completed a college course in health and social care this year
- Continues to act as a peer mentor to others at the social detox project
- Remains alcohol free
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