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Every thoughtless diagnosis and label cascades through generations of families
Des Spence, p 37

Employers should help employees who misuse alcohol

Pre-emptive action, such as confidential screening questionnaires and advice for staff, would be a cost effective way for employers to reduce harm and increase productivity among workers who drink too much, writes **Don Shenker**

Organised drinking games used to be part and parcel of the armed forces' operating procedure for team building among recruits, I was just recently reliably told. I was then hastily told that this no longer occurs. But the workplace culture of mixing alcohol with off-duty relaxation and stress management remains as strong as ever in the United Kingdom's private and public sectors.

Workplaces have long had a complex relationship with alcohol. On the one hand group drinking has a motivational function among colleagues, fostering greater team spirit and acting to reduce stress. However, on the other hand, those who cannot control their drinking and whose drinking impairs their productivity are in danger of being sacked. Who is ultimately responsible, the employer or the employee?

Heavy drinkers can manage many years of functioning reasonably well at work while colleagues and managers turn a blind eye to occasional lapses in performance—until the problematic drinking can no longer be ignored.

One quarter of the UK workforce, about seven million people, drink at hazardous levels.[1] This is a considerable health harm and, as opposed to dependent drinking, stays under the radar, usually unnoticed. This hazardous drinking causes 40% of workplace accidents, results in 17 million lost work days a year, and costs the UK economy an annual £7.3bn (€8.5bn; $11.7bn).[2] Studies in Australia[3] and Finland[4] show that alcohol consumption is positively associated with the number of days of sickness absence for men and women.

Thankfully some, but not all, employers now have clear policies to ensure that staff must report to work alcohol free; that drinking is not permitted while staff are on duty; and that procedures are in place to support staff whose drinking is affecting their work.

What is often missing is any preventive work to reduce the risks of problem drinking in the first place. Some employers are therefore at risk of funding expensive treatment services for staff dependent on drinking, while providing little evidence based preventive activity to reduce the risk of hazardous drinking.

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It is ultimately more cost effective to prevent and reduce harmful drinking . . . compared with the costs of managing dependent drinking

Using standardised screening for alcohol misuse—for example, AUDIT (the alcohol use disorders identification test)[5]—and providing brief interventions to identify and reduce risky drinking, are highly effective and cost efficient measures among NHS patients in primary and secondary care.[6]

What is innovative is encouraging the use of these techniques in the workplace, with workforces in general, to prevent alcohol related harm and sickness costs. What's important is for employers to encourage all individuals to understand more about their own drinking. How much are they drinking and what risk does this pose to their health?

Offering staff confidential use of AUDIT and brief advice as a self awareness initiative at work, whether through face to face interactions or leaflets, may well help prevent problems with alcohol at an earlier stage.

In this way, staff, who may be concerned about their drinking or whose level of drinking is not yet apparent to them, can assess the risks their drinking poses to their health and take appropriate action. Reducing hazardous drinking also reduces the risk of dependent drinking occurring.[7]

Online alcohol interventions in the workplace offer further advantages of anonymity, privacy, scalability, and constant accessibility.

US research has shown that, over a four year period, for every $1 spent on screening staff with AUDIT, providing brief advice, and referring to specialist treatment, companies saved $4 in sickness costs, absenteeism, presenteeism (attending work while sick), and recruitment.[8]

We still need to research the best incentives for encouraging staff to assess their drinking through workplace initiatives. How can we encourage heavy drinkers to take action, and what support options would heavy drinkers in the workplace prefer to help them cut down?

Employers need also to be convinced of the business case for prevention rather than cure—that is, that it is ultimately more cost effective to prevent and reduce harmful drinking in the general working population, compared with the costs of managing dependent drinking among a minority of staff.

Employers can help staff get the balance right, protect them from harm, and also contribute to a general reduction in alcohol related harms and costs to society.

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FROM THE FRONTLINE **Des Spence**

Labelled for life

Teenagers get a hormonal mainline rush of adult insight that sends them into a spiral of mental agony. They fight against parents to try to define themselves; they don't want to be us. Childhood is not about defining what you want to be but what you don't want to be. Yet we all remain captive to our childhood: try as we might, we can't change who we are or where we come from, or free ourselves from the emotions we develop as children.

Therefore, I am deeply concerned by the modern medical fad of labelling children who are often yet to reach school age, as dyslexic, dyspraxic, autistic, or having attention-deficit/hyperactivity disorder. These are not labels but tattoos. How do these indelible marks affect children's lives? Will they undermine self belief, damage relationships, and make these children question becoming parents themselves, for fear of passing it on?[1]

I often see young adults worried that they will develop mental illness or requesting blood pressure, cholesterol, and cancer checks and the rest

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But there is a much bigger problem. Risk factors that have morphed into full blown diseases—such as hypertension, high cholesterol, and osteoporosis—now ensnare entire populations. The overdiagnosis of, for example, breast cancer, thyroid cancer, and melanoma, has turned millions of the unsuspecting well into "cancer survivors." And mental illness is now the norm rather than the exception, with only 17% of adults in the United States reporting "optimal mental health."[2]

There is constant news chatter about breakthroughs in cancer genetics. The biological model of mental health has won the war for psychiatric causation and is the pretext for widespread psychotropic polypharmacy. It is assumed to follow, therefore, that mental illness must be genetically inherited, and popular culture says that these "illnesses" are passed down from our parents. So I often see young adults worried that they will develop mental illness or requesting blood pressure, cholesterol, and cancer checks and the rest. If we have been careless about the effect of label-gun medicine on patients, we are utterly thoughtless as to the consequences for their children: widespread unnecessary health anxiety.

And there is little research (and most is unintelligible) on intergenerational effects of a diagnosis of illness. But every thoughtless diagnosis and label cascades through generations of families. This is medical myopia at its worst and abdication of our duty to protect the well. This iatrogenic harm wrecks our children's sense of wellbeing forever.

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A CONSULTANT'S TAKE **John Dean**

Referral mismanagement systems

Referral management systems are teams led by general practitioners that aim to improve the efficiency of referrals from primary care to specialists. But the evidence seems clear: they do not improve access; they increase costs; and they preferentially target high referrers, not the worryingly low ones.[1]

Referral rates to clinics can vary 10-fold between general practitioners working at the same practice. And it drives those of us who work in these clinics nuts. The rapid access chest pain assessment clinic that I help run has clear and simple rules printed on the referral form: send us patients with recent onset chest pain that suggests angina.

But many patients referred to us don't have symptoms remotely like angina; some have had symptoms for years (and been thoroughly investigated); and some have no chest pain at all. I often feel like a greengrocer whose customers keep asking for half a dozen pork chops. What's worse, when I recently queried a referral, I discovered that it was never the general practitioner's intention to send the patient to our clinic at all. The system had redirected the referral against the general practitioner's wishes and quite inappropriately.

But that is only part of the problem. Who is hunting out the low referrers, those who are hoarding scores of undertreated patients who should be offered the opinion of a specialist?

What's wrong with sending referrals directly to named consultants? General practitioners soon twig that the specialists with the shortest waiting times aren't necessarily the most efficient. But to the managers we are all the same. These systems distort communication between healthcare professionals, but rather than hang their heads in shame, those behind these systems seem rather proud about it.

Last year I visited the Devon Access and Referral Team and was introduced to the six clerks who run the phones for cardiology referrals (yes, six, just for cardiology). They were clearly dedicated to their work and told me how difficult they found it to tell patients who ring up that their appointment won't be for three months ("But . . . I'll be dead by then.")

Who is hunting out the low referrers, those who are hoarding scores of imperfectly treated patients who should be offered the opinion of a specialist?

We could easily improve hospital services for general practitioners and patients if these functions were taken out of call centres and brought back to the front line. The Devon system costs about £1.5m (€1.8m; $2.4m) a year to run. This doesn't represent good value for money.

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