

14th January 2003

National Alcohol Harm Reduction Strategy
Consultation - Department of Health

Dear Sir/Madam

Please find enclosed our comments on the questions outlined in your consultation document, which we have answered or left, according to whether they have some relevance to the work we do. I hope they are of use to you in the development of the strategy.

As a brief introduction, we work in a direct access hostel for the homeless that includes a detox unit and “dry” flats and move-on accommodation for people who need an alcohol-free structure to their housing. Further to this, we have initiated an “Assessment Unit” for long term street homeless people, who often have a street-drinking history, with the view to assessing their needs, encouraging the development of “living skills,” and supporting them in their move to the most appropriate form of re-housing. We both also co-ordinate the Rough Sleepers Initiative in the area and have a knowledge of the street-drinking community and the local services that are available to alcohol dependent individuals.

If further information is needed please do not hesitate to contact us.

Yours faithfully,

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Senior Supported Housing Officer

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National Alcohol Harm Reduction Strategy

1. The point at which the Government should get involved is when : there is a visible cost to society / community, in terms of crime, harmful trends

within family systems, financial costs to the economy, when vulnerable groups are at risk, where there is a high level of alcohol-related deaths and when alcohol is having a negative effect on the quality of life of groups and individuals.

2. It is important to emphasise choice, and people are in a better position to make mature and well-informed choices when they have a more complete information about safe drinking and the effects on health. It is the Government's responsibility to ensure there is well promoted information available to allow individuals to have greater responsibility in their decision making. The Government has a further responsibility for individuals who are less able to have responsibility because of certain vulnerabilities: susceptibility to alcohol addiction (genetic or because of life events), learning difficulties, children, the elderly, mental health sufferers, etc In short, it becomes more of a responsibility for government the more the ability of an individual to take responsibility is impaired, but the emphasis should still be on choice. So to offer services for "individuals" who are "in need" due to alcohol.
3. To look only at the point at which individuals have a negative effect on communities in terms of crime. Sensible choices need to be made around housing, especially for the elderly. Important to recognise the different definitions of 'community:' For instance we work with Street Drinking Communities, who to a large extent have their own codes and traditions and even support systems and can function despite the use of alcohol. In these circumstances it is important to respect the community and the individuals rights to belong to these, but to give help and assistance to allow them to exist and have a good quality of life within a larger community.
4. N/A
5. The principles that should underline a national harm reduction strategy:
 - Recognition of variety within society - the different cultural meanings and significance of alcohol for different groups.
 - Recognition that alcohol is used for very different reasons by individuals.
 - The importance of well informed choice around the effects on health and society. Clearly marked health warnings.

- The principle that any national strategy must be ‘needs-driven’ to be effective, so well researched and flexible to changing trends.
 - Relativity. Not everyone will respond well to the same solutions - so there must be choice; treatment centres, controlled drinking plans, educational resources.
 - Effective assessment of need. In the case of our clients with severe addictions and/or a history of homelessness, we have found that an assessment/discussion period to determine what individuals would most benefit from, leads to a more successful outcome.
6. The factors that make alcohol misuse different to alcohol use are:
- Either physical or psychological dependency on alcohol
 - Continued use despite obvious effects on health.
 - When alcohol significantly changes personality traits. EG causing them to behave in a way they would not have done otherwise - For instance we work with individuals whose offending behaviour has a direct link to their alcohol use. Also alcohol has been proven to make individuals more likely to self harm or attempt suicide.
 - When the effects of alcohol are contributing to poor mental health; IE psychosis or paranoia.
 - When Alcohol is used medicinally (in the mind of the user), E.G. individual is aware of the amount needed to feel a certain way and uses alcohol as an antidote for physical or mental health reasons as a “crutch.”
 - When alcohol use has a negative effect on the individual’s quality of life or on the quality of life of those around them.
7. An alcohol harm reduction strategy needs to seek to effect a range of different drinking patterns.
- Firstly, it needs to concentrate on those drinking patterns that can lead to unmanageable behaviour - see Qu. 6 on alcohol misuse. This means linking with the criminal justice system, social services and the NHS.
 - Secondly, through better education on the negative effects of alcohol and controls on marketing, giving everyone a better- informed choice to examine and change their drinking patterns.
 - Thirdly, the strategy needs to provide adequate and accessible alcohol services for those who want to change their drinking patterns. Often we have experienced a large waiting list for those waiting for treatment, detox or counselling. This group is most susceptible to change.

The Government should concentrate efforts in prevention only for the first example - (severe misuse- crime, unmanageable behaviour, negative effect on health, danger to other vulnerable people) and even then, should take into account that other solutions, like controlled drinking, may be more effective and long-lasting.

8. Alcohol seems to be used by the individual where they feel there is a lack of support or understanding. In terms of social changes the increasing divorce rate means that more of our residents cite marriage break up as a reason not only for the beginning of alcoholism but for the continuation of it and for any relapses that occur.
9. Other groups to focus an alcohol strategy upon would be:
 - People who are homeless, have insecure housing arrangements or those in hostel or nightshelter accommodation. Many will have a history of alcoholism and street drinking already and will find their housing situation can accentuate their addiction. Other vulnerable people in this situation can find that the culture of street-drinking can be easily picked up and quickly entrenched.
 - Ex-drug users are susceptible to alcohol use; often its used as a “crutch” and can become just as addictive.
10. We work closely with a street-drinker community, that is based on the tradition of sharing alcohol and this (albeit with the negative aspects, mentioned) can be the most long-term support network that individuals have. We try to work flexibly within their existing structure when offering housing support because it is important to recognise that this culture of companionship is a valuable part of their quality of life.
11. Age groups have an effect on drinking patterns; young people are more susceptible to advertising and trends, whereas we have found the older and more entrenched drinkers will have a tendency to drink the same drinks in the same ways, subject only to financial constraints. We also find that within the drinking culture there are sub-cultures such as “street drinkers”, “pub drinkers”, “social drinkers” and “binge drinkers”.
12. Family background can very often be seen to play a role in the development of behaviour around alcohol. There are proven links between parental use of alcohol leading to children developing a range

of problems, including alcoholism in later life. The vast majority of alcohol abusers that I have worked with have, in their formative years experienced alcoholism, an insecure family background, a form of abuse or have been in social services care. Therefore harm reduction needs to be focused at these vulnerable groups of young people and their parents at an early stage, through social services and school counselling and guidance around safe parenting. Equally, adults who have experienced an insecure background and use alcohol need to be able to access services where they can explore the influences on their behaviour that has led to alcohol misuse.

13. Use of alcohol will reduce concerns over its risk disproportionately, but this will vary according to use. Facts need to be available so that individuals have the choice of whether to let risks affect their usage. Recently we were able to influence a long-term street-drinker by giving him a some fact sheets relating to safe drinking levels, measurement of units and effects on health and explaining what they meant to him. He read them over a period of time and has decided to cut his drinking to around half of what it was.
14. Factors that determine harmful/ problematic drinking:
 - When amount that is being drunk becomes a Physical Dependency, and tolerance is high and often increasing. This means that the level of alcohol is detrimental to health, but also that it will have a control over the drinker. They will need to continue to sustain the amount to avoid the danger of withdrawal e.g seizures, parkinsonian tremors, hallucinations, in severe cases this can lead to coma and hospital admission.
 - When the drinking is contributing to other physical health problems - Eg not taking important medication or rendering it useless for complaints such as diabetes or epilepsy.
 - Mental Health effects. E.G. psychosis
 - Increased likelihood of harming themselves or others.
 - Behavioural issues, crime and social disorder caused by alcohol.
15. Unknown. But all research should be clearly publicised.
16. We would be unable to know figures relating to costs, but having experienced working with street drinkers, I have seen a lot of strain put

on the ambulance service and A & E department due to alcohol-related collapses, injuries and seizures. These could be largely preventable through investment into controlled drinking and clear warnings about the particular dangers of binge drinking.

17. The most appropriate means of treating alcohol dependence and misuse are found through having an assessment period for clients to talk through what could work for them and the choices and funding available for a range of services. Dual Diagnosis creates a problem through services “bouncing” a client between the mental health and addiction services as there is a lack of recognition played to this client group and training is needed in being able to work with clients who are chaotic and still using “alcohol”. We have witnessed the problem of people being on waiting lists too long and losing commitment before they can get to treatments. Professionals would benefit from having information regarding alcohol and its effects to give to clients, as well as a knowledge of the links with mental health. Also training around harm minimisation, as there is a significant proportion of people who will not stop misusing alcohol, but still need a housing and care solution. Often appointments in various fields are cancelled if the individual smells of drink which shows a lack of understanding of “alcohol addiction”.
18. More education is necessary in this area as alcohol is usually accepted by an individual's peer group and long term work is needed to properly educate individuals. Brief interventions as far as we are aware have not been used often in our area of Surrey.
19. Access to treatment is dependant on local authority and funding and would benefit from being better co-ordinated nationally, with more emphasis put on prioritising need. Theo, please say something about effectiveness of treatment etc. Community solutions, where individuals can have a more gentle approach to recovery, in the form of counselling and Alcoholics Anonymous are often followed, and these services could be better funded and more available. Fact sheets for those wishing to access any services would be helpful, to allow individuals to choose the best approach for them and to work out the best way to access it.
20. The need for alcohol arrest referral workers. Specific residential treatment centres. Increased education. Alcohol been given specific

workers within addiction teams. The setting up of alcohol action team's similar to the D.A.T's.

21. Unknown

22. Very significant links exist between alcohol misuse and mental health problems. As mentioned, alcohol misuse can lead to psychosis ("Alcohol induced psychosis") and increases the likelihood of self harm, and alternatively alcohol can be misused by an individual to numb the mental health problems. There needs to be a more co-ordinated response between alcohol and mental health services, because both service, which are often stretched, will seek to push clients to each other resulting in many people falling in the middle of the two services and receiving no follow up from either. More funding into Dual Diagnosis services and treatment. We have some experience of alcohol treatment centres making no allowance for mental health sufferers: When the substance misuse stops, then mental health problems can surface. Some treatment centres do not allow clients to be on medication, which will therefore exclude clients who need medication to stabilise depression or schizophrenia, but need to address their alcohol use.

23. - 33. Currently out of our 17 individuals tackling their alcohol addiction by being on a clean and dry licence (e.g. total abstinence) 13 have served time in jail, 5 are on probation and five have on-going court cases. Alcohol has been a factor in at least 75% of these offences. One client has over 30 offences of drunk and disorderly, or drunk and incapable. It is hard to say the impact of other factors the only constant is alcohol mis-use. Street drinking laws serve only in pushing the problem away from urban centres and making it hard for them to engage with service providers and residential units (e.g. hostels and night shelters) that are usually centre based. I believe that it is behaviour that should be policed and therefor A.S.B.O.'s (Anti Social Behavioural Order's) and not no drinking zones are more helpful to the individual and services. Educating people in terms of breathalysing (e.g. drink drive protocol) and showing levels of alcohol in the system may work for "rowdy" pedestrians and low level social disorder.

34. We can develop many of the principles of Drink-drive policies into alcohol harm reduction:

- It puts clear a clear limit on what is acceptable to drink. This could be translated into health limits; EG there being as much of an awareness around safe drinking for health as there is around safe drinking around driving. Clear limits and an explanation of units.
- The Drink-driving campaign raised awareness of the ways alcohol affects driving judgement, this too could be clearly demonstrated in other aspects of life. EG effects on children, domestic violence, crime, suicide, unwanted pregnancies, risk of rape. Clear factual advertising.
- The campaign made drink-driving socially unacceptable, demonstrated by the amount of reports made by the police by the public. This could be translated into an alcohol policy, in terms of it being socially unacceptable to behave in a certain way, providing it doesn't alienate individuals and push them away from services.
- The use of breathalysers. This has been transformed from use by the police to use in alcohol treatment. We use breathalysers to protect the dry environment in the hostel as well as to conduct controlled drinking plans with clients.

37. People in unstable accommodation or rough sleepers are at risk, because of the potential violence or manipulation in situations where there is a high level of alcohol use, as well as being vulnerable to the development of alcohol dependency themselves. This is especially the case with young people, for example those leaving care or those new to this environment. A possible solution is giving Outreach teams good training in alcohol issues and ensuring that individuals do not become entrenched in rough sleeping, hostels and nightshelters and street drinking.
38. Addressing alcohol misuse as a complex problem is important. In the case of working with clients who are rough sleeping or in supported accommodation it is good practise to assess carefully the reasons why they are at this particular point and look at the layers of issues and events. Rarely is alcohol the root of the problem and it may be covering up or combining with other problems. There needs to be more counselling available, for example bereavement, victims of abuse, victim support, family separation, debt counselling.
39. Joined up delivery has worked well in certain partnership groups such as homelessness strategy groups and various consultation bodies.

Alcohol may need a similar set of working bodies set up through the civil service.

Education and Communication

45. I find that when discussing safe drinking levels with long term drinkers, that they were confused by the unit system and by the different strengths of beers. Could this be more clearly defined - especially as the audience who should be most aware may have problems working out amounts.

The beers drunk by street drinkers are “super-strength” and are almost double the strength of other beers. This needs to be more clearly displayed on the packaging.

47. families and parents are heavily involved in many primary alcohol rehabilitation projects and should be educated on the current problems with young drinkers and the need to be a role model in terms of “healthy” drinking.