

Berkshire Healthcare Trust

10th January, 2003.

Dear Colleagues,

The National Alcohol Harm Reduction Strategy Consultation Document

Thank you for the valuable opportunity of responding to the above consultation document. This response has been collated collaboratively from the NHS services for patients with Drugs and Alcohol problems in Berkshire.

We have several general comments to make as well as some specific responses to some of the questions posed in the document.

1. Many services for substance misusers are joint or integrated services, the splitting off of funding streams for Drugs from Alcohol has had a paralysing effect on services for alcohol patients and/or those presenting with co-morbidity, whose primary problem may be alcohol. It is disappointing that the National Treatment Agency has not been proactive in encouraging Drug Action Teams to start planning the development of Alcohol services in line with Drug services.
2. The abuse of Over The Counter, Prescribed and Performance enhancing drugs are now a huge problem. Some users regularly mix and match substances. There needs to be recognition in respect of the amount of damage being done to the individual, communities and families. The amount of harm is more than twice the scale than harm from drugs.
3. There seems to be a trend towards finding something positive about alcohol use rather than accepting the harm and tackling it. There is very little evidence of any positive effects. The research that has been done is based on middle-aged men. This does not take in to consideration the harm done to unborn children, young men, women, children, adolescents and the elderly.
4. What we know about the pub culture is that people are encouraged to drink more, smoke tobacco and can gain access to illegal substances through contacts in pubs. The Government should be promoting the idea that it is possible to enjoy leisure time differently. People accessing our services are becoming physically dependent

- on alcohol much younger. Recent research tells us that many 11-15 year olds are regularly drinking alcohol. There is more disposable income available to young people and many have fallen into heavy drinking as a way of life. Cheap alcohol is on sale everywhere, including petrol stations. Many young people can be seen driving off the forecourts drinking beer as they leave.
5. In many towns in the South East the 'happy hour' is promoted at times when the working day finishes so many people go straight to the bar or pub from work. The increase in the 24hour economies has meant that there are more pubs; bars and clubs open until 2 or 3 am. If councils are granting licenses to so many, what is being done to provide help to those whose alcohol use becomes problematic? The government could increase the price of alcohol. The money raised could be put towards helping those who are in need of assistance with dependence or misuse.
 6. Under-age drinking is rife; shops are not checking the ages of young people who purchase alcohol. Stricter controls are needed in order to make salespeople personally responsible for alcohol sales. Make the laws as strict as they are for the purchase of fireworks.
 7. If the drink drive limit were lowered the number of deaths would reduce as people would not be testing themselves and tempted to have 'one more'. This is well demonstrated by the introduction of compulsory seatbelts, where many lives have been saved.
 8. When are we going to have health warnings on alcohol? Other countries have started to do this and we know this works, as has been seen with tobacco. It is time to tell the public the truth about the harm that alcohol does.
 9. Harm reduction is a continuous process that follows engagement and treatment of individuals, as well as education and support. Alcohol dependence is a chronic, relapsing condition. It should be considered like a long-term illness, requiring ongoing support, such as Diabetes.
 10. We are aware that an Alcohol Treatment Strategy document has been written but has never been published. We are also aware that many sporting events are sponsored by the drinks industry, which have an interest in keeping the nation drinking in order to make money. Should this be at any cost?

Specific Health Issues

1. There has been no extra funding from DOH for Alcohol treatment services for around 20 years.

2. The amount of money spent on dealing with Alcohol problems is 25% of the health budget. The amount of staff damaged is also high as in the numbers of staff addicted and assaulted by individuals under the influence.
3. Our definition of harmful drinking is “Any drinking that causes harm to the individual and may be recognised as such by the individual, the law, the family or employer”
4. The DOH should insist on all Trusts having a Substance Misuse policy and ensure that all Managers are trained in the application of such a policy. Staff could be randomly tested for drugs and alcohol. This would help to make the working environment safer for all.
5. All advertising and sponsorship of Alcohol should be banned. The use of positive prevention advertising such as “don’t drink and drive” should be encouraged.
6. Work could be done with the media to resist the glamourisation of alcohol seen on television. More emphasis is needed on other aspects of life to show us that there is more to life than sitting in the pub.
7. Work to reduce the stigma associated with having an alcohol problem, it can affect anyone who consumes high levels regularly.
8. There are no “safe” drinking limits in pregnancy and this should be stated.
9. DOH should make it compulsory for Trusts to prosecute individuals who assault staff when under the influence. This should include verbal threats, as well as physical assaults. The environment that all staff is working in must be safe and health Trusts must ensure that this happens.
10. Consult with colleagues in Police Forces who hold statistical evidence concerning alcohol’s links with assaults, domestic violence, sexual crimes and criminal damage; as well as the drink/driving offences associated with alcohol.

What else can be done?

1. Resources must be targeted more effectively. If you tack alcohol issues on to drugs the current DAT co-ordination teams do not know anything about alcohol.

The focus will then move from health to crime to the detriment of the health and welfare of the patient. The current Drug Action Teams do not collaborate well with providers; purchasing equipment that may not be compatible with the systems we already have, thereby potentially wasting large sums of money meant for patient care.

2. Health trained Primary Care Facilitators are needed. These would be based with GP's in Primary Care but linked in with Substance Misuse services. They would screen and carry out treatment for those with less severe alcohol problems. They would refer on those with more complex problems to secondary care. This would give GP's much needed support and breathalysing and Drug Screening could be carried out in Primary Care. This avoids stigmatising the patient.
3. The Models of Care tool is an excellent document and is meant for Alcohol and Drug problems so this provides a professional framework for Integrated Care pathways and should be rolled out, resources permitting.
4. Implementing the DANOS standards is crucial as some people are working in the field that have set themselves up as experts. E.g. Brief rapid private detoxes. Some lone workers call themselves "specialists" GP's may believe these titles and prescribe to the recommendations with potentially life threatening consequences.
5. There is well-documented evidence of the effectiveness of Motivational Enhancement Therapy and Cognitive Behavioural Therapy. A recent local audit in Berkshire has demonstrated the effectiveness of Detoxification.
6. If they were more resources we would recommend the collection of alcohol data on the Drug Treatment Monitoring Unit forms. This would provide valuable data for future service planning.
7. It is essential that individuals have the opportunity to self refer to services as well as via the usual referral routes. Occupational health departments should continue to work closely with service providers.
8. Mandatory training should be provided for Publicans on the Management of Alcohol Intoxication and first aid/recovery information for all staff. The refusal to serve someone intoxicated should be a legal requirement on all bar persons in order to prevent deaths from excess alcohol.
9. Instalment prescribing of Benzodiazepines for Alcohol withdrawal should be available everywhere.

10. Alcohol and Drug Liaison Staff should be available in all Accident and Emergency departments to ensure that patients are engaged and managed effectively.

We hope our comments will be useful in your plans to produce a Harm Reduction Strategy for Alcohol in 2004.

Please do not hesitate to contact us if you require any further information about any of comments.

Yours sincerely,

Ann Brown
Clinical Service Manager

Radhay Jugdoyal
Clinical Service Manager
CASCADE

Marion Walker
Clinical Divisional Head (West)
Substance Misuse

Joyce Prior
Clinical Divisional Head (East)
Substance Misuse
CASCADE