

Response to National Alcohol Harm Reduction Strategy Consultation Document

From Camden & Islington Mental Health & Social Care Trust
Substance Misuse Services

Health: prevention, treatment and the impact on the NHS

14. Harmful drinking is usually described as being above the sensible drinking guidelines, e.g. 21 units for men and 14 for women. However it can be useful to think about harmful drinking as being any alcohol consumption that causes harm to an individual physically, psychologically or socially. It may also be that a person's drinking can harm others e.g. partner or children. One of the problems with alcohol consumption is that the amount of alcohol consumed and the harm done is very variable depending on each individual. E.g., a man who drinks 50 units of alcohol over the course of a weekend in a binge pattern can feel that his drinking is not causing any problem, yet another man drinking the same amount may suffer from blackouts, become verbally aggressive leading to fights and lose time from work. It is often easier for people to think about harmful drinking in terms of units consumed, as this is concrete and quantitative. In reality, the issue is more subtle than this and needs to take into account a number of different factors.

There are many factors that can be taken into account when deciding whether heavy drinking has become problematic drinking. Heavy drinking can vary in quantity and pattern depending on each individual, their gender, social situation, ability to tolerate alcohol and what is perceived to be the cultural norm for them. In helping an individual decide whether their drinking is problematic, a full drinking history needs to be taken, looking at the amount of alcohol consumed, the pattern, frequency and changes over time. This then needs to be related to how this affects the person's physical health, their mental health and social situation. What is perceived as problematic to one person may not be seen as so by others. In defining problematic drinking, it is vital to present the effects of a person's drinking to them in a clear non judgemental way that enables them to decide whether their drinking is problematic or not. This also involves explaining what could happen if they continue to drink in the same pattern.

This question is far more complex than merely saying that a certain amount of alcohol consumption constitutes harmful drinking and anything less than does not. Perhaps this illustrates the particularly difficult place alcohol has in our society and the fact that our feelings towards alcohol consumption are at best ambivalent and at worst contradictory.

15. Key references include:

- Alcohol – can the NHS afford it (2001) Royal College of Physicians
- Alcohol Policy & the public Good (1994) Griffith Edwards et al
- Tackling Alcohol Together, Raistrick & Heather

17. Alcohol awareness needs to be included in training at all levels. It is important that in this is included not just as the range of problems that alcohol causes, but also information on the likely success of interventions since in our experience there appears to be a lot of therapeutic nihilism among health care professionals.

18. We have experience and some success in using brief intervention in primary care and acute hospital settings. One of the main limiting factors is encouraging staff to identify excessive alcohol users – whether by simply asking about alcohol or using a screening questionnaire such as AUDIT. For this to be successful it requires that the whole practice (in primary care) or the whole ward or hospital (in an acute hospital) is supportive of responding to alcohol problems. Difficulties include not understanding the range of alcohol related problems, perceived lack of time, feeling unable to do anything about it or feeling unsupported to do anything. There needs to be support from a managerial level for screening to take place. (See work by Clement on the importance of therapeutic commitment not just by the individual but by the organisation – in Stockwell & Clement (eds) *Helping the Problem Drinker: New initiatives in community care* (1987)).

19. For review of treatment effectiveness for alcohol, also see March 2002 edition of *Addiction*, especially paper by Miller et al “Mesa Grande”. Modalities of treatment that have a good evidence base but appear not to be widely used in the UK include Community Reinforcement Approach and Contingency Management / Behaviour Contracting.

Treatment should be widely available. As well as specialist alcohol services based in their own premises it is helpful to have satellite / outreach services. We run satellites in primary care and drug services (to work with individuals who misuse both drugs and alcohol). We are developing liaison services to the acute hospitals.

20. There are positive aspects from the current drug treatment and prevention strategy, which could be adopted by the Alcohol Services. The first step is the creation of a strategy within the agreed time scale and its adoption by the government of the day, to parallel the Drug Strategy and provide a framework for action.

The provision of best practice guidelines to be adopted by statutory and non-statutory providers and implemented in client care pathways.

The negative aspects in drug treatment, which need to be avoided, are the extent to which users are segregated and stereotyped. 90% of the adult population will use alcohol at some time and need to be informed and educated about making positive choices.

It is important to reinforce positive choices that clients have when drinking and acceptance that to relapse is an essential element of the ‘change process’, and a learning opportunity.

21. Suggested interventions in A&E depts could be divided into two categories:

- Binge related harm
- Chronic drinkers requesting detox.

The aim would be to stop the repeat attendees from needing to come back to A&E for crisis interventions, and to give the one-off attendees advice on how to prevent harm happening again. To this end, we would suggest at least one A&E professional per shift (as a satellite worker from the specialist alcohol services – attached to either A&E dept or Mental Health Liaison Teams is trained in alcohol related brief interventions, has access to information on alcohol agencies within the patients catchment area to which the patient can be referred, and able to give information sheets out on prevention rather than crisis intervention. Anyone who comes into A&E with alcohol related harm should be offered this routinely.

A pilot project of one session per week in an A & E dept, which ran for a period of one year, was inadequate and ownership of the project by the host department was difficult to establish. At the Paddington Project at St Mary's, Praed Street, London when they reduced the alcohol liaison from 5 days a week to 3 days a week the number of referrals dropped dramatically. Together with our experience this suggests the importance of a full time presence in A&E if intervention with alcohol problems is to succeed.

22. There is a clear pattern of alcohol use and mental health problems with the clients who use our service. Some of the mental health problems are created by excessive use of alcohol e.g. anxiety, depression, hallucinations, aggression, self-harm and suicide. Equally clients who have acute emotional problems or an enduring mental health diagnosis, will on occasions use alcohol to medicate one or more of their symptoms eg anxiety, depression – if they feel the symptoms are becoming intolerable and alcohol provides a brief period of relief.

The process of co-ordination is about assessment of client needs and communication with clients and other health and social care workers.

The Camden & Islington Mental Health & Social Care Trust has created a Dual Diagnosis Strategy Group and aims to train all community and ward staff in the issues related to mental health and alcohol use plus on going supervision groups for staff, on-going support/education groups for clients and assessment and liaison with the Alcohol Service. To incorporate alcohol use and treatment into the care plan involving the client's key worker, is an essential first step to raising the issue.

The social care aspects of a client's mental well being need to be reviewed and will include housing, personal finances and occupation. Helping to maintain individuals in the community and improve the quality of their lives requires taking a holistic perspective on the whole person.