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NATIONAL ALCOHOL HARM REDUCTION STRATEGY

Response to Consultation Document

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I am a member of the BPS, the BABPC and Alcohol Concern and continue to hold my UKCC nursing registrations. I am currently studying for the PGCE(FE).

The views expressed in this document are not those of the MOD but my own, based on research and clinical experience within the alcohol treatment field and in the wider NHS and psychiatric services of the MOD.

PRINCIPLES THAT UNDERPIN THE STRATEGY

Taxation on alcohol is a major source of revenue for the Treasury and, therefore, Government, having vested interests in the sale of alcohol, should take commensurate major responsibility for the production, advertising, distribution and consequences of the population using this drug. Government intervention at all levels is therefore justified.

CULTURAL AND BEHAVIOURAL ISSUES AROUND ALCOHOL USE AND MISUSE

- 6 Any use of alcohol that causes problems for the person or others should be considered as alcohol misuse. Areas implicated in the consequences of alcohol misuse are health, workplace, family, crime including domestic violence.
- 7 Reducing overall consumption with the aim of promoting sensible drinking (no more than 21 units for men 14 units for women per week) should be the ultimate aim of the strategy. Levels of consumption are directly related to cost and the preventative measure of increasing the costs of spirits and extra strong lagers, ciders and beers, whilst decreasing the cost of weaker alcoholic and alcohol free drinks would appear to be a reasonable strategy.
- 8 Increases in income, availability and social approval of drinking/heavy drinking have affected overall consumption. Social disapproval of cigarette smoking has been a major influence to change. However, whilst Government does not consult

the producers of illicit drugs regarding the illicit drug strategy it continues to include the drinks industry in all consultation regarding the question of alcohol misuse. This group, predictably, continue to express the view that the problem of alcohol abuse lies with the individual and not the substance, minimising the perception of risk for the majority. The disease model has been discredited within the scientific community but continues to dominate the attitudes of the general public, and indeed professionals and government. A strategy which highlights that all people that consume alcohol could be at risk at some point, eg. at retirement, when mixing with heavy drinkers, on being bereaved etc.

- 9 Availability, cost, advertising and lack of alternatives to drinking would seem to be a major influence on consumption by young people. However, undue concentration on this group can give the impression that the problems of alcohol misuse are mainly in young people, whereas the problems of alcohol misuse are cross generational, and are often not recognised or addressed in the elderly. Similarly, when looking at ethnic minorities, the use of alcohol should be viewed in the context of the group where issues of poverty, deprivation, lack of alternative leisure activity etc., are likely to have a major influence on alcohol consumption. It is also pertinent to point out, in view of the major investment by Government in tackling illicit substance misuse, that many young people experiment with drugs when disinhibited by the effects of alcohol.
- 10 Accepting that most people enjoy drinking and that drinking in moderation is not harmful it is safe to assume that alcohol will continue to be used within our culture. However, many users of illicit substances, would use the same arguments, as indeed would many people involved in socially proscribed activities, but this does not tend to impact on government strategies when looking at dealing with these activities. I would suggest that vested interests all too often concentrate on the positive aspects of drinking in order to divert attention from the difficulties arising out of alcohol misuse.
- 11 Drunkenness appears to be more acceptable within the UK, whereas a steady drinking rate appears to be the norm on the continent. However, before advocating the drinking style of France, for example, the higher incidence of cirrhosis should be taken into account. Heavy drinking appears to be more prevalent in the north of England, however, services for alcohol problems are concentrated in the south east.
- 12 All areas listed have major influence over behaviour, however, having worked clinically in the alcohol field for some years casualties of alcohol misuse are cross class, cross gender and cross generation. Whilst problems are more easily identified in the poor statistics of death from cirrhosis and falls demonstrate that professional classes are more likely to suffer in these areas. Affording to finance an alcohol problem often delays recognition of chronic problems. It would seem that cost, marketing, legal and environmental initiatives should be first line strategies, with education (of professionals and general population on risk and

recognition), and clinical intervention (with a range of early, brief interventions to more extended treatment packages), should form second line strategies.

- 13 The vast majority of people are unaware of the risk of drinking. As long as the “disease model” of alcohol problems persist, people are likely to see the risk in terms of the vulnerable few who are perceived as being susceptible, i.e. “if I do not have bad genes, family history of alcohol misuse or a poor constitution I am not at risk”. This general perception is at odds with the fact that the cheaper and more available alcohol is the more people develop problems of alcohol abuse.

HEALTH: PREVENTION, TREATMENT AND THE IMPACT ON THE NHS

- 14 Drinking above recommended limits increases risk. Any pattern of drinking which causes problems for the individual, their family, workplace or society should be considered problematic drinking. Even those drinking within limits may exhibit problematic behaviour if, for example, driving after drinking.
- 15 For evidence of costs see “Alcohol our Favourite Drug”. Evidence on health benefits is dubious i.e. The beneficial components of red wine (giving the message that drinking is good for the heart), can be isolated and delivered minus the alcohol. It would be naïve to assume that the massive costs to the NHS, Industry etc., outweigh the economic benefits to those having vested interests, e.g., producers, distributors, leisure industries and government. The greatest gap is in linking evidence from health, legal, social services, workplace etc.
- 16 The cost of £3 billion to the NHS has been identified by the Department of Health. However, costs to multiple agencies, such as Social Services, Legal system, etc., are all interlinked. If viewed in simple terms of economics and costs to government then £3 billion is negligible in comparison with economic benefits in employment, revenue, however, should costs in terms of human misery and wasted potential be taken into account the scale of the problem may be taken more seriously.
- 17 The cost of alcohol is more likely to effect reduction in consumption over the whole population and, therefore, less people are likely to fall into the harmful consumption category. Education, of all health and social service staff, in early recognition and brief intervention, should be carried out by experts in the field of alcohol treatment. Currently many professional gain only minimal training and those carrying out training often fail to make the links between alcohol misuse and many physical and mental health problems. It should be noted, however, that education and recognition, where there are no quality services to offer treatment, would be a futile exercise.

- 18 Many studies have found brief interventions for non-service seekers (i.e. Those whose alcohol misuse has been recognised by screening or association with other health problems) has been found to be effective. Currently, however, recognition of alcohol as the primary problem is often missed and treatment of secondary problems then becomes ineffective. Education of all health service and social service staff in recognition and delivery of brief interventions will improve outcome. When patients are unwilling to address the alcohol problem at least the services will be aware of the primary problems which will effect other interventions.
- 19 There are a range of effective interventions but few services or specialist alcohol treatment workers. Within the NHS I would draw to your attention the work of the Windsor Clinic, Alcohol Treatment Unit, in Liverpool. Twice awarded the Government Charter Mark for excellence this clinic has a twenty five year record of treatment backed up by research. This is now one of the very few services exclusively targeted at people with alcohol problems. The combination of illicit substance misuse services with alcohol services is, I believe, detrimental to the latter, which is in fact the major problem.

Motivational Interviewing and Cognitive Behavioural approaches have been demonstrated to be effective. However, Project Match, demonstrated that all interventions delivered by committed workers can be effective and a range of services need to be available.

- 20 I am not qualified to comment on the success or otherwise of these programmes but am aware of the boost in funding to this area. Given the relative size of the problems I would hope that funding to back the National Alcohol Strategy would be as generous and in proportion to the problem.
- 21 I would refer you to the National Handbook of Alcohol Dependence and Problems, (Heather, Peters and Stockwell, 2001), part 1V, which examines this area.
- 22 Whilst the part played by alcohol is now being recognised in attempted and completed suicides, interventions recommended often seem to overlook treatment of alcohol misuse. For example, whilst Williams (2001) in an excellent book "Suicide and Attempted Suicide" identifies alcohol as a major feature he concentrates his recommendations on the treatment of depression. He fails to point out that alcohol misuse often produces similar symptoms to depression and, in my experience, eliminating alcohol from the equation results in the disappearance of depressive symptoms in most of those receiving alcohol treatment.

It is of paramount importance that both mental health workers and patients make the link between symptoms of depression, anxiety, panic, etc., with the misuse of

alcohol. This failure, in my experience, has led to many unsuccessful interventions with clients eventually referred to alcohol treatment services. It should also be stressed that once the alcohol problem has been addressed clients should have access to treatment for residual problems which, again in my clinical experience, amounts to approximately 5% of clients entering alcohol treatment services.

CRIME, DISORDER AND ANTI-SOCIAL BEHAVIOUR: THE EFFECTS ON OUR SURROUNDINGS AND COMMUNITY

I would refer to the home office publication "Alcohol and Crime: Taking Stock" 1999, regarding this area. Whilst I am aware of many links between alcohol and offending I believe that staff from the police, probation, social services and prisons have more expertise than I in this area.

THE IMPLICATIONS FOR VULNERABLE GROUPS

I would again defer to the opinions of social workers and those involved in the care of children in this section, or clinicians such as Professor Richard Velleman who has specialised in work with families of people having problems of alcohol misuse.

EDUCATION AND COMMUNICATION

Whilst alcohol misuse in young people is highlighted in the media the problems of many serious crimes, chronic health problems, domestic violence and child abuse should be targeted more seriously. The accent on the problems of the young and perhaps more dramatically the problems of illicit substance use and misuse often serves to make the general population (and it would seem government and health care professionals) complacent about their own use of the drug ethanol.

Government messages have been unclear in the past and the last major publication of the sensible limits gave confusing messages. It should also be added that this was seized upon by the media to state that drinking is good for you at the same time that the annual drink driving campaign at Christmas (1995) occurred.

We must be aware, as demonstrated by the DARE campaign, that educational initiatives which prove popular with educators, parents and young people, have been proven to be **ineffective** in changing behaviour.

Information provided by GP's in a non-judgmental fashion has been shown to be effective and more work needs to be carried out in this area.

Education on recognition and brief intervention to personnel staff and managers may also effect earlier recognition and intervention.

Any government initiative to assist people recognizing problems of alcohol misuse needs to be backed up by intervention initiatives and a range of quality services offering various levels of treatment.

THE SHAPE OF THE MARKET AND MARKET-BASED SOLUTION

I would reiterate the point that the drinks industry's prime concern is with maximizing profits. When drawing up the Drug Strategy the Government did not consult the Columbian Cartels, nor the distributors etc. Whilst alcohol is legal the strategy should deal with alcohol misuse in the terms of drug misuse.

When considering solutions involving the market costs should reflect alcohol content. Strong lagers, ciders, beers and spirits should have large price increases. Weaker drinks and alcohol free drinks should be cheaper.

The alcohol industry should be taken to task for advertising drinks specifically aimed at young people, particularly women.

ECONOMIC COSTS AND BENEFITS OF ALCOHOL

I have made reference to the above in previous sections.

ADDITIONAL COMMENTS

Whilst I would accept that the alcohol industry provides major income to government I take issue with the consultation document referring to alcohol contributing to "personal and social wellbeing" for many. Having a drink may be pleasurable for many people, as are many activities, both legal and illegal, but this does not particularly add to personal and social wellbeing. I doubt that documents looking at smoking, illicit substance use, viewing pornography etc., would discuss these behaviours in these terms.

It is stated that this consultation is about a National Alcohol Harm Reduction Strategy and yet many of the questions asked and comments made make reference to benefits of drinking to the person, treasury, drinks industry. Was the same consideration made of vested interests when drawing up the National Drugs Strategy.

Costs of good education and treatment should take into account factors other than financial. The human misery caused and the failure to reach potential by those directly or indirectly affected by heavy drinking should also be included in the equation.

I am aware of conflicting interests by Government and assume that, in the past, this has been reflected in poor investment in the field and apparent minimization of the problems caused. I sincerely hope that this exercise is serious in its' intention to reduce the harm that alcohol causes. I have worked in this field for a number of years and have witnessed both the misery that alcohol causes and the success of people undergoing treatment.

I would stress again the size of the problem compared to that of illicit substance misuse. Whilst the latter gains more publicity and funding alcohol misuse presents a larger and more widespread problem in society. Subsuming the treatment of alcohol problems under the umbrella of the DATS has led to poorer services. Many people not yet dependent on alcohol but experiencing major problems as a result of heavy drinking are reluctant to attend drugs services. It seems that all funding and major initiatives are currently directed towards the drug services and that clients with problems of alcohol abuse are commonly excluded from mainstream services.

I hope my comments are of use in this consultation and would put forward the plea that, when the project group completes the National Strategy and moves on to other things, the initiative and recommendations are followed through.

Should I be able to assist in any other way I am more than willing to do so.

Brenda Coldwell.