

COMMENTS ON SU/DOH CONSULTATION ON NATIONAL ALCOHOL HARM REDUCTION STRATEGY

I am taking the opportunity submit my comments on the consultation document for the National Alcohol Harm Reduction Strategy. I write as Manager of the East Kent Community Alcohol Service in which I have worked for more than 20 years. During the same time period, I have worked regularly in training alcohol and drug counsellors at the University of Kent and I continue in my capacity as Honorary Lecturer at the University. I have taken the opportunity to consult extensively with my 15 clinical staff within the alcohol service and the views which I express here concur with those held by members of my team and also many of my academic colleagues.

I welcome the attempt to arrive at a National Strategy and also the opportunity to contribute to the consultation process. Specifically, I hope that the evolution of an alcohol strategy will go some way to redress the imbalance which seems currently to exist in England and Wales whereby services for those affected by the misuse of drugs other than alcohol have received much attention, funding and general support whereas alcohol services seem to have been somewhat overshadowed. I am aware that the consultation document covers many areas but I will confine my own comments principally to the area of treatment for those experiencing alcohol-related difficulties and the training of workers to operate effectively when offering help to such individuals. I will make my points briefly but would be very glad indeed to have the opportunity to expand on any of the thoughts which I offer.

- I hope that we can avoid excessive concern with definitions of alcohol problems, epidemiological questions and unnecessary bench-marking activity. There is a huge and respectable literature of research and observation in the field of alcohol misuse both in the UK and beyond and I think that many of the questions raised within the consultation document have already received robust answers. We must imagine that our population will continue to use alcohol regularly and accept the ‘Lederman principle’, namely, that the level of problems of all kinds associated with alcohol misuse will correlate directly with the overall level of consumption within the population.
- Treatment for those adversely affected by alcohol misuse has shown to be very effective. Whilst it is possible to isolate those approaches which seem consistently effective from those which seem consistently ineffective, it is difficult to suggest that any one of the effective approaches has clear superiority over its competitors. However, we have several decades of research which show that the effectiveness of any treatment approach offered to alcohol misusers will be dramatically affected by the competence of the worker offering the approach. In short, if competent and effective helpers are able to establish helpful alliances with their clients, this will positively influence the outcome of treatment.

My own practice and research interests have concerned themselves with the experience of role-security in alcohol counsellors and there is much which we can apply from previous experience which is conducive to high levels of role security and therapist competence. There is ample evidence that the relationship between worker competence and outcome extends to substances other than alcohol and also into the field of generic counselling and psychotherapy. I welcome the arrival of the Drug and Alcohol National Occupational Standards (DANOS) and would emphasise the need to provide proper training

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programmes and support mechanisms for workers in this field which has otherwise a very high rate of staff burnout and turnover.

- The National Treatment Agency does not yet have a formal remit to oversee alcohol treatment services yet the Models of Care document repeatedly makes reference to both drugs and alcohol. There are many elements of the Models of Care document which are helpful in the alcohol field but others which are far less appropriate and which may even function as hindrances to good practice within the field. I hope that it will be possible to give consideration to the specific needs of alcohol misusers, the properties of alcohol as opposed to other drugs and other important matters rather than that we should run the risk of subsuming matters relevant to alcohol misuse under the guidelines which have been found appropriate for drugs other than alcohol. Space and time do not permit me to enter into a detailed elaboration here but I would be very pleased to participate in some more detailed exploration in the future.
- I think it probable that the treatment of alcohol problems will become formally subject to management by the National Treatment Agency. Already, our organisations are shadowing this anticipated situation in that the services which we provide are effectively commissioned by the local Drug and Alcohol Action Team. It is apparent that the NTA has produced much paperwork and that it has been prone to exert high degrees of pressure in order to achieve its aim of improving the quality of treatment for drug problems. I am in no doubt that increased bureaucracy and insistence on tight time-frames has given rise to stresses in treatment provision which may be paradoxically unhelpful in the aim of improving the quality of treatment. Like many other providers, I am keen to improve the quality of what is on offer to those affected by alcohol misuse but I am forced to acknowledge that the pressures placed upon commissioners and providers alike via the National Treatment Agency seem sometimes to be counterproductive.
- Whilst it is correct that we should concern ourselves with best practice and require the evidence base wherever possible for treatments which are offered, there is a risk of excessive homogenisation and standardisation which may stifle the opportunities which exist to offer personalised and meaningful treatments to afflicted individuals. Attempts to standardise assessment and treatment processes have to be balanced with the need to retain flexibility and respect for the circumstances of particular individuals and I am not convinced that this is currently understood by those within the National Treatment Agency.
- I think it quite likely that the strategy will require more action in respect of those whose use of alcohol is associated with crime and disorder. I understand that there is some pressure to create something equivalent to the Drug Treatment and Testing Orders (DTTO's) for alcohol misusers. We agree that it is correct to confront the link which may exist between an individual's drinking and his/her criminal activity and that there may be situations in which it is helpful to exert some degree of pressure for a given individual to make changes in his/her drinking. However, we have concerns regarding the possible impact of an emphasis on compulsion and coercion in treatment upon those who may need to seek help other than on such a mandated basis. It may be difficult to integrate those on compulsory orders to seek treatment with those not subject to such orders, particularly within modalities such as group therapy.

In a more general sense, we are anxious that criminal activity becomes increasingly viewed as a matter appropriate for “treatment” – a view which can be counter to the definition of this term in more conventional systems of health service delivery.

- We accept that there will be those who can be helped to address their alcohol problems more effectively with some degree of compulsion in the background. However, we hope that there will be an opportunity to consider the practical and ethical implications of a situation in which choices made by responsible adults become viewed as symptoms of illness requiring treatment.
- The Models of Care document lists treatment modalities which have most to offer for those helping opiate addicts and particularly, those administering Methadone over long periods. Models of Care does not explicitly address the question of alcohol treatment in sufficient detail. For example, family therapy is not currently included as a recommended option for treatment within drug services yet it is difficult to think other than of the enormous benefits which this modality may offer to those drinking inappropriately and those affected as a consequence.

I am aware that I have given a somewhat sketchy reference to some important issues regarding treatment and training in the alcohol field and hope that it may be possible for me to be involved in a more detailed examination of some of the matters which I have raised. Finally, I would like to express a personal wish that we should reduce the legal limit for driving whilst under the influence of alcohol from the current 80 mgs to 50 mgs/100 mls in accord with many of our European neighbours. I hope that you will feel able to contact me if I can provide any further input to the consultation process.

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