

Response to the National Alcohol Harm Reduction Strategy Consultation Document

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THE CULTURAL AND BEHAVIOURAL ISSUES AROUND ALCOHOL USE AND MISUSE

Alcohol misuse is not specifically defined in the international classifications of disease. Rather DSM IV describes alcohol abuse and the ICD 10 harmful use. Broadly these diagnostic criteria would be synonymous with alcohol misuse.

DSM-IV Alcohol Abuse (1 or more criteria for over 1 year)

- Role Impairment (e.g. failed work or home obligations)
- Hazardous use (e.g. Driving while intoxicated)
- Legal problems related to alcohol use
- Social or interpersonal problems due to alcohol

ICD-10 A pattern of psychoactive substance use that is causing damage to health; the damage may be to physical or mental health.

Thus I would define alcohol misuse as a pattern of alcohol use that has an adverse impact on an individual either directly or indirectly (e.g. via the society in which the individual lives). The impact can be physical, psychological or social.

A harm reduction strategy should address the drinking patterns within the population as a whole. Those demonstrating harmful drinking are part of that distribution. There is evidence to suggest that reducing the drinking of the population as a whole reduces the proportion of those drinking excessively. In addition particular groups should be targeted including those drinking non-sensibly, binge drinking young adults and dependent drinkers. The government should concentrate its efforts on the population as a whole informing society of the impact of certain drinking patterns thereby promoting sensible drinking and encouraging disapproval of certain alcohol related behaviours. The high proportion of non-sensible drinkers should be targeted for education and brief intervention. This should be accompanied by an investment in treatment services for those who wish to address their drinking behaviour. There is little evidence to suggest that current interventions during schooling are effective, this should be a priority area for research.

Some of the most important factors that influence drinking behaviour are availability and acceptability. The government is responsible for the former and influences the latter.

Knowledge of, and attitude to, risk can influence behaviour, as in the example smoking in which such information has been combined with a lack of acceptability within the population.

HEALTH: PREVENTION, TREATMENT AND THE IMPACT ON THE NHS

Published data indicates that the nadir for safe drinking is approximately 1-2 units per day – possibly even lower. Hence any heavier drinking is associated with increased risk of psychological or physical morbidity. Furthermore the curves described are ‘j’ or ‘u’ shaped. Therefore the whole spectrum of drinking should be considered.

There is clear evidence for alcohol related health costs, the difficulty arises when quantification is required. Christine Godfrey is the UK expert in this area.

Availability of alcohol and acceptability of drinking related behaviour are key in preventing alcohol related problems including dependence

Brief intervention has been demonstrated to be effective in individuals who drink non-sensibly. Lifestyle questions including drinking behaviour are routinely included in health screening at GP surgeries when an individual registers. There are other opportunities that are currently unrealised including attendance at casualty departments and admission to hospital wards.

Medically assisted detoxification from alcohol is highly successful with more than 95% completing detoxification. However long term abstinence rates are poor and with around 20% maintaining abstinence at 1 year. Much research has been completed in the US in an attempt to identify effective treatment and target these to individuals who will respond. Project MATCH was unable to identify which individuals would respond to the three different treatment modalities: Twelve-step facilitation, motivational enhancement and relapse prevention. There is also good evidence that practically based treatment approaches are effective (for example those that address accommodation, time and work) but these are not generally adopted by statutory treatment services. Research should be conducted into different approaches and treatment outcome.

The Portman group have published information related to reducing alcohol related assaults within the public house situation. Some responsibility for such incidents, which occur outside of such establishments, should also be borne by landlords and there should be a responsible licensing approach. If there is crime and disorder associated with certain establishments then the landlord should work with the police and other authorities to minimise this harm. Practical approaches include use of safe glasses, restriction of happy hours, avoiding traffic crossing in pubs and removal of pool tables! Tim Stockwell in Australia has completed some excellent research in this area.

There are high rates of depression and anxiety in alcohol dependent individuals. The Epidemiological Catchment Area study in the states indicated that 13.4% of those with a diagnosis of alcohol dependence were comorbid for depression and 19.4% for anxiety disorder. My clinical experience indicates that in 90% of these individuals such symptoms will improve on stopping drinking. However dual diagnosis, which also includes other psychiatric conditions such as schizophrenia, is a major problem to both substance misuse and psychiatric services with such clients needing more input with generally a poorer response. Models that have been considered include joint working, specialist service and facilitation within adult mental health. Currently dual diagnosis clients in Croydon are jointly managed between Adult Mental Health and Substance Misuse. Three Dual Diagnosis workers and shortly to be appointed to work with, and between, the current services.

CRIME, DISORDER AND ANTI-SOCIAL BEHAVIOUR

I believe that a mechanism of responsible licensing should be introduced such that conditions and responsibilities are placed upon those obtaining and renewing licences to minimise venue harm. Other approaches that could be considered include arrest referral and treatment orders. I believe that in part drink-drive polices are successful because of the change in public opinion regarding drinking and driving. I also believe they would be more successful if the public were informed about blood alcohol levels and drinking behaviour as there is a great underestimation of the amount of alcohol that an individual consumes before they reach the legal limit of 80mg per 100mls in blood.

THE IMPLICATIONS FOR VULNERABLE GROUPS.

Teenagers and young adults are particularly vulnerable often due to acute intoxication.

EDUCATION AND COMMUNICATION

From government data the current sensible drinking message is confused and poorly understood. Furthermore it is ineffective as the levels of non-sensible drinking continue to rise in both males and females.

THE SHAPE OF THE MARKET AND MARKET-BASED SOLUTIONS

The government, the drinks industry and alcohol services should work together to provide a forum in which drink related issues can be discussed and resolved without individual interest distorting the interaction.

THE ECONOMIC COSTS AND BENEFITS OF ALCOHOL

As discussed above Christine Godfrey has analysed this area. The cost-benefit of treatment should also be considered.

DELIVERY OF AN ALCOHOL STRATEGY

- how I think this could be integrated within current structures.

ELEMENTS OF AN ALCOHOL STRATEGY.

1. AVAILABILITY AND ACCEPTABILITY OF ALCOHOL

2. TREATMENT

3. COMMUNITY SAFETY, CRIME AND DISORDER

4. SPECIFIC AND HIGH RISK GROUPS

5. RESEARCH

DELIVERY OF AN ALCOHOL STRATEGY

I believe that it is essential that alcohol be taken under the jurisdiction of the DAT and NTA. As such each local area should appoint an alcohol coordinator to work alongside the DAT co-ordinator. A separate co-ordinator is required as asking the DAT co-ordinator fulfil this role would dilute and disrupt both activities. This individual's role would be to co-ordinate and develop the response to alcohol locally. This could/should include uniting the local services, planning and implementing training and application of the impending alcohol strategy.

AVAILABILITY AND ACCEPTABILITY OF ALCOHOL

Public information

Knowledge regarding alcohol and its effects in the general population is relatively poor. The public message relating to sensible drinking limits is confused with conflicting information relating to sensible or safe drinking (e.g. weekly and daily limits). More recently a publication in the BMJ (White et al., 27 July 2002) has cast doubt on these limits indicating, "substantially increased risks of all cause mortality can occur even in people drinking lower than recommended limits, especially among young people." Major changes in smoking behaviour have occurred through public awareness and disapproval of smoking and perhaps alcohol consumption is more like smoking than previously thought. The evidence base should be examined and if necessary further research conducted so that the public can be given accurate information on which to base choice.

Public policy

Public policy should be critically examined, adapted and adopted. There is considerable evidence that availability and acceptability of alcohol affects consumption. This information should be reviewed, the evidence considered and licensing policies brought into line with the evidence. Furthermore there should be responsible licensing with those selling alcohol taking some responsibility for the effects of their sales. For example if alcohol related violence is associated with particular pubs or clubs then there should be an early and effective mechanism for influencing change such that this is reduced.

TREATMENT

Specific treatment services

The evidence base for the various treatment approaches should be evaluated. Treatment resources to deliver effective treatment modalities should then be calculated and made available. For example medical staff, specialist nurses/workers, liaison workers, inpatient beds, social workers, rehabilitation funding required per 100,000 head of population stratified by age and social structure. Funding should be made available to provide these services locally. In addition pump priming for some areas will be required where services fall below adequate levels e.g. to identify appropriate facilities such as buildings.

Working with primary Health

Primary health care personnel are in a unique position to identify and manage individuals with alcohol related problems. Brief intervention with heavy drinkers and alcohol detoxification in the community have been demonstrated to be effective interventions. Training and support should be provided to enable them to fully exploit this opportunity and mechanisms established for closer working with specialist services. Funding of GP liaison nurses should be considered and specific funding for GPs who work with alcohol clients. Consideration should be given to establishing/funding pharmacies that can supervise alcohol detoxification (e.g. daily pick-up with breathalyser readings) thereby increasing efficacy and safety. In addition such individuals could advise on further treatment and help.

Working with General Hospitals

A substantial number of people attending hospital are drinking alcohol at hazardous levels. A hospital-wide strategy for detecting and responding to alcohol problems should be pursued and an alcohol liaison worker employed to work between the hospital, psychiatric liaison and specialist alcohol services.

Adult mental health

Closer working between general adult psychiatry and specialist alcohol services is essential to improve the treatment of dual diagnosis clients. Specialist training in alcohol problems should be provided for community psychiatric teams. Mutual support and communication should be established and protocols for joint working developed.

COMMUNITY SAFETY, CRIME AND DISORDER

Crime

Arrest referral schemes should be extended to include alcohol. An equivalent of the DTTO (Drug Treatment and Testing Order) should be considered or more formal treatment approaches as a condition of probation. Bringing together those addressing these issues such as probation, police, those considering the nighttime economy and alcohol agencies should enhance the development of joint approaches.

SPECIFIC AND HIGH RISK GROUPS

Young people

Alcohol consumption is increasing in young adults and the increase has been particularly profound in young women. Our research has demonstrated that 90% of the alcohol consumed in this age group is in a non-sensible manner, that is greater than Government recommended limits. Such a change is establishing the foundation for future alcohol related problems. Drinking in this age group and interventions to reduce consumption are a matter of extreme importance.

Ethnic communities/minority groups

Where uptake of alcohol services by ethnic communities is less than would be expected from the sizes of the populations concerned research should be undertaken to explore the reasons and to identify approaches to improve access.

RESEARCH

Research funding should be identified to support further projects. For example our research has not been specifically funded but is identifying a disturbing pattern of alcohol consumption in the general public. Also it is clearly demonstrating that "it's not what you drink but the way that you drink, and that's what brings bad results" Funding should be made available to fund research across the spectrum from predisposing factors, through drinking behaviour and public knowledge to treatment outcome. These areas are highlighted in the Alcohol Concern publication "100% proof".