
National Alcohol Harm Reduction Strategy Response to Consultation Document

My response to the consultation document is from the perspective of a nurse consultant in dual diagnosis. On a personal level I drink alcohol myself and although on occasions I have consumed alcohol in a harmful way (the hangover has proved it!) I do not consider myself to have ever had an alcohol problem.

I have responded to the points on which I think I have something specific to contribute.

Principles underpinning strategy

1. Despite the risk of accusations of being a ‘nanny state’ I believe the government has a responsibility to promote notions of social responsibility and obligations, and good citizenship. People’s drinking behaviour fits within these. The massive costs of alcohol related harm to the NHS, social services and the criminal justice system also justify intervention.
2. Alcohol use/misuse is a matter of individual responsibility but when it has a negative impact on others, individually, or as a group, other agencies, including government should exert an influence.

Cultural and behavioural issues

6. Alcohol misuse is drinking behaviour that leads to adverse physical, psychological, psychiatric, interpersonal, social or legal consequences for the individual and/or those in her/his immediate social network (eg partner, children) and wider community (eg work colleagues, neighbours)
7. Any drinking which is above the ‘sensible’ drinking guidelines regardless of whether this is consistently drinking at, or above, 4 units daily for men and 3 for women, heavy daily use or ‘binge’ drinking.
8. I think there has been a trend towards introducing workplace drinking policies which have made ‘working lunches’ and other drinking during working hours less acceptable. I think the development of such policies has to be a matter for individual companies/organisations but government can encourage them to consider this.

More generally, in the same way that cigarette smoking has increasingly come to be seen as unacceptable and antisocial I think that attitudes to heavy drinking and drunken

behaviour can shift. I think over the past 10 years or so there has been a change in attitudes to drinking and driving such that large numbers of people view it as irresponsible/antisocial.

9. I agree that young people need to be a focus. People with, or susceptible to, mental health problems are a group that also require particular attention. Important information is available in the National Confidential Inquiry Report into Homicides and Suicides by People with a Mental Illness (DoH 2001) and the National Suicide Prevention Strategy (DoH 2002).
11. The association between alcohol and English football remains. It is likely that alcohol has played some part in football violence. While much has been done there is no room for complacency. Having a beer (or two) as part of the preparation for, and celebration after, an important match is part of the fun!
12. Marketing of alcoholic drinks and the image associated with particular brands is very influential. If non-alcoholic drinks were marketed in a way which made them more 'cool', 'macho', 'healthy' (depending on the target audience) this may provide an important counter balance. The relatively high financial cost of non-alcoholic drinks in pubs (in comparison with alcohol) can be a disincentive to drinking them.

Health: prevention, treatment and the impact on the NHS

14. I would define harmful drinking in a similar way to alcohol misuse – see Q 6.
16. As well as hospital treatment which is required for people who have been in accidents or the victims of violence which is alcohol related and those who experience physical health problems in which alcohol use is a factor, alcohol is a factor in the hospital admissions of significant numbers of people with mental health problems.
The impact of the drinking of NHS staff themselves should not be forgotten.
17. Re-training: In addition to any formal teaching I think it is essential for people to gain practical experience eg through placements, visits to projects etc. Much greater attention needs to be paid to alcohol (and other substance misuse) in the curricula of health and social care professionals' preparatory training.
19. Yes. I encounter people who have been past patients who are alcohol free, some several years after they have received care/treatment. However, it is important that a range of treatment options are available to meet the very different needs of different people.

In my own area there are a range of different treatments and treatment agencies available. This includes voluntary and statutory provision, different types of specialist in-patient treatment (crisis admission, short stay detox programmes, longer stay detox programmes – allowing for fuller assessment of physical and mental health and social problems, out-patient services (community detox, support/counselling), day programmes/drop in facilities (some informal, others more structured), counselling services, AA, supported alcohol free hostels. Waiting times for some services, particularly the longer stay inpatient service which best caters for the needs of more complex clients (those with mental and/or physical health problems associated with their drinking), are a concern. The service is **excellent** and does its best to prioritise those waiting according to need but many clients have to wait for several months. (Alex One at the Bethlem Royal Hospital, part of South London and Maudsley Trust).

A new post which will provide substance misuse (alcohol and drugs) education/training to local general hospital staff (in A & E and on the wards) and assessment and follow up of patients, should improve patient care for those admitted due to physical health problems. In the past patients have had withdrawal seizures or experienced delirium tremens because staff lacked the knowledge and skills to adequately assess and treat them.

One gap in service provision is for residential rehabilitation for people with more severe/complex mental health issues and alcohol problems and/or poly substance use. Such people are frequently excluded from the provision that does exist.

Another gap is provision of supported accommodation for people who want to continue drinking or are unable to stop. Some, especially if they are older, are particularly vulnerable.

People need to be able to access services through a variety of routes. Care pathways, as outlined in the Models of Care (DoH 2002) document, should facilitate this. The continual re-assessing of clients as they access different services should be reduced. This is a potentially major obstacle in facilitating a seamless approach to the client care.

22. Alcohol can trigger or exacerbate depression and anxiety. There is strong evidence of its association with suicide. It is almost certainly a contributory factor to some violent incidents in psychiatric inpatient wards. When used in combination with other central nervous system depressants (whether prescribed medication or illicit substances) it increases the risk of overdose (accidental or deliberate). Alcohol use is often a precursor to self-harming behaviour. Some people with mental health problems ‘self

medicate' with alcohol - a means of dealing with their symptoms. Significant numbers of people with alcohol problems drink as a means of blocking out painful past life experiences, childhood sexual abuse is common.

Some people lose their places in mental health hostels because of their drinking and/ or the consequences of it. This can have a range of significant consequences for them as individuals and for the organisation of their care – once they have worked their way through all the hostels in a locality the person will need to be placed in another borough and their care transferred.

Despite effective work in some areas, I hear of mental health services who will not see people who have alcohol problems as they see them as the responsibility of alcohol services. Where care is provided negative attitudes and lack of understanding of the problems associated with alcohol use can result in poor care provision.

Co-ordination of services as outlined in the Dual Diagnosis Good Practice Guide (DoH 2002) and Models of Care (DoH 2002) is the way forward. However, some people will not fit neatly into services. In particular people who do not have a serious mental illness, and hence fall outside the remit of mental health services, but nevertheless have significant problems and are often at high risk of suicide. These are often people with a diagnosis of personality disorder. They are likely to be known to a variety of services, (GP, A&E, psychiatric liaison services, they may be admitted to inpatient psychiatric wards overnight, or for a few days, when particularly suicidal, they may have had contact with substance misuse services but not engage well and/or continue to drink because it is their only way they know of coping with eg their childhood sexual abuse) These people do not fit the criteria for any particular service and they therefore tend not to receive ongoing work from any one agency, or any consistent approach. They are extremely challenging to work with and, by and large, the services they do come into contact with want to pass them on to someone else as soon as possible – they are seen to be a problem, not rewarding to work with, can be extremely time consuming and any changes they do make tend to be made slowly. Working with people like this requires highly skilled practitioners with good support and supervision mechanisms.

From contacts I have had with people in other parts of the country I understand that in some areas these people may be placed on enhanced CPA and hence have a care co-ordinator. With the pressures on inner city services, certainly in London, this does not happen.

Vulnerable groups

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36. The children of people who are heavy drinkers are vulnerable to the impact of their parents alcohol use, eg through neglect and to developing alcohol problems of their own in later life.
37. As already noted – people with, or at risk of, mental health problems
People with problems with other substances are also at risk/vulnerable eg risk of death from combination of CNS depressants (eg heroin, alcohol, benzodiazepines), overcoming dependence on one substance and substituting it with alcohol. Alcohol use is not always given sufficient attention by drug services (as suggested by the NTORS study eg Gossop et al 2001).
38. The full range of problems which can be associated with alcohol use need to be considered: physical and mental health problems, social issues (eg finances, accommodation, impact on family), use of other substances, legal issues, risks to self and others.
Interventions cannot address just one area since people's needs in various domains are inter-related. A comprehensive, inclusive approach to care/treatment is needed.
39. The separation of alcohol from drugs in terms of policy, funding streams, organisation of services etc inhibits a joined up approach to service provision. I think including alcohol in the remit of the National Treatment Agency and the local Drug Action Teams is essential. Funding issues need to be considered and at least a pragmatic approach taken to allocation of funds – alcohol is a drug – it just happens to be legal. However, if the separation is to continue ring-fenced money for the development of alcohol provision would be welcome. One thing that gets in the way of joining services is a sense of Compton and having to defend one's own corner. Alcohol only services tend to feel under valued and ignored in comparison with drugs agencies.
At a local level the lack of integration between health and social services also inhibits a joined up approach being taken. Mental health teams have been integrated for some years now, substance misuse needs to catch up. Social services personnel wanting to hold on to and protect their budgets is an obstacle.

Despite the barriers good working relationships 'on the ground' between local services promote joint working. Nevertheless the need which different agencies seem to have for each client to go through their own assessment process hinders seamless care/treatment provision.

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40. Each client is different and some are able to access mainstream services. Special provision, which can be flexible and has the time for providing significant input to each client, and also has skilled, experienced staff, is also required.

Education and communication

41. To raise awareness and change attitudes and behaviour.
43. The sensible drinking message is not widely known – many people have little idea about what the limits are and, even if they know the numbers, they often do not know what a unit of alcohol is in practice. This ignorance includes health care workers.
45. There is a need for significantly more education regarding alcohol in the training of all health care workers (at preparatory and post-qualification levels). Addressing this need could be a way of disseminating information more widely (to the general public).
48. National advertising campaigns can make a big impact – I think people remember the falling tombstone of the AIDS campaign and the withdrawing opiate addict claiming ‘I can handle it’. The drink driving campaigns have also been important. A snappy campaign informing about safe drinking limits and the risks associated with excessive use could be very effective in making people reflect on their drinking and prompt them to find out more.
50. I would ban alcohol advertising and alcohol sponsorship.

Economic costs and benefits of alcohol

60. Alcohol helped me get through the latter stages of my PhD, which, in turn, helped me to obtain my current job!

Additional points

- I have serious concerns about the proposed change to the criteria for detention under the Mental Health Act made in the Mental Health Bill ie it would be possible to detain someone on the basis of their alcohol use.
- I think guidance regarding the care/treatment of people with personality disorders and alcohol problems, including which service(s) could/should be responsible for co-ordinating their care would be welcome.

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References

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