

The following is a response to the consultation document concerning National Alcohol Harm Reduction Strategy from the Addiction Directorate of Avon & Wiltshire Partnership Mental Health (AWP) Trust. These comments reflect the opinions of (in alphabetical order):

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We work within NHS Statutory Specialist Drug and Alcohol Services and have concentrated our comments on aspects of health and the provision of treatment and care. We have not, therefore, commented on all aspects.

We assume that the facilitators at the DOH of this process will already be aware of key documents such as the Royal College of Physicians Report 'Alcohol - Can the NHS afford it?', 'Alcohol Strategy' produced by Alcohol Concern and 'Tackling Alcohol Together' by the Society for the Study of Addiction. In addition, we are aware that the Scottish Strategy concerning alcohol has been published (December 2001) with an extensive evidence based review of the literature.

Specific comments :

The Principles that should underpin the strategy

1. The Government should get involved with managing the harmful effects of alcohol due to its damaging health and social consequences. We feel that is more reasonable to ask "why would the Government not get involved?". To not get involved would be an abdication of responsibility. The degree of problems resulting from alcohol misuse far out-weighs that involved with drug misuse and the Government has been heavily involved in promoting targets in this area. Without Government led initiatives leading to targets, alcohol services have not been developed. There has been in effect a planning blight. We suggest that alcohol should be considered to be placed within the remit of ACMD.

In terms of 'when does Government intervention become justified', it is not clear what the roots of this question are. We feel that is appropriate for the Government to be involved in the prevention of alcohol problems at all levels. It is crucial for the Government to intervene [e.g. education, prevention] at a more general public health level where more people are involved than only at the severe end of dependency. [see Prof Griffith Edward's book on 'Alcohol Policy and the Public Good'.]

2. Clearly, alcohol misuse is a matter of individual responsibility. However, the Government and others have responsibilities to intervene when it is causing problems to others and also to ensure there is adequate provision of services across all tiers / domains of treatment to problem drinkers and others e.g. family members. Since the Government provides funding for health and provision of services, clearly they have a key role to play.

3. ditto
4. The individual person has responsibility for his or her own use of alcohol. All business involved in the production, distribution and selling of alcohol also have responsibilities: including giving accurate information about ABV etc through labelling, responsible marketing and advertising, training of bar staff etc, use of proof of age cards etc.
5. The principles that underpin a national alcohol harm reduction strategy should include : to reduce harm to individuals and to society, to improve treatment, to provide better training, screening and preventative measures and to raise awareness of problems related to alcohol. There is also much that can be done (supported by the evidence base in Britain and other countries) in relation to Public Health and Social Policy to develop and support an environment that reduces the development of problematic alcohol use and promotes the resolutions of such problems.

The Cultural and behavioural issues around alcohol use and misuse

6. Alcohol misuse can be defined as resulting from any level of consumption which leads to serious negative consequences. These may be in the area of serious medical health and social consequences, which may be in physical, psychological, social and forensic domains.
7. It is not about levels of consumption but **any use that results in harm**. Prevention should be targeted at all levels, although clearly the largest proportion of people are those drinking excessively in a non-dependent fashion causing harm to themselves and society. We suggest that improved screening is needed to prevent further harm that may have resulted from alcohol misuse [e.g. if somebody presents with injuries from an alcohol-related incident or with alcohol associated medical problems who at present do not receive any information or advice specifically about the role alcohol has played in their difficulties or strategies to help themselves]. Such patients identified in a range of generic settings would benefit from brief interventions or referral onto specialist services thereby reducing the likelihood of further harm that may have resulted from alcohol abuse. Refer back to comments made to questions 1 and 2.
8. No comment.
9. We agreed that there is very little offered specifically to young people. Particularly within statutory drug and alcohol services, the young are under represented. In addition, child and adolescent psychiatric services do not routinely offer drug and alcohol treatment. This is not a key/core part of their training and should be addressed. [Notably alcohol problems in older people are also under represented in services and is likely to be due to lack of identification, attracting older people into services etc.]

Whilst we are aware that statutory services may not reach out to many different populations, we do believe in the principle that services should be accessible and people should feel that any cultural needs are respected. There are issues around this however, with the possibility of many and contrasting needs. Whilst not wanting to ignore such populations, we should be realistic as to what we can develop and make sure that services are not indulging in tokenism.

Concerns have been expressed regarding whether treatment services are accessible for women. Our local experience is that men and women are represented at assessment in accordance with prevalence but that in Bristol, for example, more women than men are entering treatment programmes. In this centre, we do offer women-only treatment programmes at later stages of abstinence. However, notably we are seeing those women at the severe end

of dependency and worryingly the average age of women attending tends to be younger than that of men.

There is also another major issue with respect to focussing on 'other groups': current services are hugely overstretched and under-resourced. If we are to expand our service provision (which we would dearly like to do), enhanced funding will need to be provided.

10. No comment
11. Our only comment is that it is notable in our university towns that alcohol is very cheap and students are actively encouraged to drink. This seems to be an increasing and worrying trend. There are well recognised regional differences that are described in detail in the Alcohol Concern publication 'The State of the Nation 2002'

Health Prevention, treatment and the impact on the NHS

14. See question 6.

We define harm as any level of consumption that results in harm to the individual or to others. It does not rest on the amount of alcohol consumed. We believe that if the patient is dependent on alcohol, it is critical to make this diagnosis since treatment plans follow from this (e.g. they are likely to need pharmacological cover for detoxification, controlled drinking is not a realistic goal, and people are more likely to have severe sequelae from their alcohol misuse). Nevertheless, problematic but not dependent drinking can be associated with significant harm to the individual or others e.g. domestic violence, public disorder etc. As described in question 6 we explore physical, psychological, social and forensic domains for any resulting problems.

15. We think the evidence is very clear for the health costs of alcohol, but we feel some of the health benefits are more controversial. We feel that the health benefits of moderate drinking have been identified in middle age and beyond, but that health benefits in younger people have not yet been demonstrated. We direct the facilitators towards the reports outlined in the opening statements and also to Professor Edward's book on 'Alcohol Policy and the Public Good'. We feel strongly that the issue is not that there are any gaps in the evidence, rather there are huge gaps in our ability to respond, and a huge lack of leadership over alcohol issues from the Government.
16. We feel that there are both huge direct and indirect costs to the NHS with the indirect costs being more covert. We are aware locally that many people admitted to general hospitals do not have an alcohol history taken and therefore appropriate treatment is not initiated. The patient then becomes admitted and undergoes extensive investigations which may be unnecessary if their alcohol misuse had been identified. For instance, we very commonly have people referred to us who are on a number of drugs including antidepressants and proton pump inhibitors, but where their alcohol misuse has not been identified.

We also believe that alcohol misuse by staff contributes to the costs of the NHS. We are aware that in all of our respective trainings we had very little about alcohol, about how it may affect our patients for whom we care but also about how it may affect us. There is a huge degree of stigmatisation over alcohol misuse and Occupational Health departments often have difficulty in dealing with it. There is very limited resource for treating staff in a confidential manner. With limited treatment options available in many parts of the country, NHS staff may have great difficulty in receiving treatment.

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17. As stated, we believe that prevention should be aimed at the entire population in an early education forum. We are also aware that many people model their drinking behaviour on others and the expectation of what it can do. Inevitably, for some people severe alcohol problems result. Greater awareness of what may lead people to use alcohol in a problematic or dependent fashion [e.g. genetic vulnerability, impulsive actions, depression] and education about other moderating environmental and personality factors would make people better informed to make their decision about whether (and how) to drink alcohol or not. We also believe that early intervention targeted at people beginning to misuse alcohol would prevent many of the other more severe problems. Training needs to be provided at all levels to all professionals within health and social providers and allied professions such as physiotherapists, occupational therapists, radiographers and probation officers. Training needs to cover the health, social and psychological aspects of alcohol misuse and dependence. We believe that such education should be core to professional training and development, in addition to raising the awareness about alcohol problems and destigmatising alcohol misuse and dependence. We believe staffing levels need to be increased and their confidence and competency improved such that they feel able to deliver care to such patients.

Locally, training is skills based. At the University of Bristol, users or ex-patients who have achieved significant sobriety help teach medical students. This has been a very successful initiative and has shown that severe alcohol problems / dependency can affect people from all walks of life.

18. Brief intervention itself should be clearly defined. Opportunistic brief interventions (associated with screening, and done by non-specialists), and brief interventions in the sense of limited time in 'counselling' need to be distinguished. The former type of brief intervention has shown to be efficacious to those patients not necessarily seeking alcohol treatment and who are seen in an opportunistic fashion. Such interventions are not efficacious as the core treatment delivered to those with alcohol dependence. Given that such interventions should be targeted at the population which, from our experience locally, are not currently identified [i.e. those seen in general hospitals or by GPs], extensive training is needed not only in delivering this form of treatment but also in identification and screening. In addition people need to be trained and have their confidence improved so that they feel it is an effective treatment. There is a broad enough spectrum of treatments, however most areas in the country cannot deliver this full spectrum at adequate levels to meet demand. It is clear that those with alcohol dependence are as compliant with their treatment as those with other chronic relapsing remitting conditions such as hypertension and diabetes [see O.Brien CP & McLellan AT. *Myths about the treatment of addiction*. Lancet, 1996: 347:237-40.

All of this can only be delivered with resources and increased training. For instance, locally we have no dedicated in-patient services, no dedicated liaison services nor alcohol workers dealing with alcohol problems in the general hospitals. In all but one hospital locally there is no liaison psychiatric service. There is no dual diagnosis service. In addition, access to residential rehabilitation is very limited. Our local experience is that services are very drug orientated and clearly, we do not want to be subsumed into the drug services where generally alcohol then takes second place. The reality is that without Government driven targets, we do not receive any resources to improve and deliver our alcohol services to a wider population. Currently, in the drug field, initiatives appear to be driven by 'criminality' and whilst we do not want to endorse that criminal activity should be a driver to treatment services, clearly similar links need to be made for alcohol.

Within drug services there is good evidence that a large percentage of people with drug problems misuse alcohol to a significant degree or have a significant alcohol problem but the converse is not true [see Alcohol Concern's report]. Many people with alcohol problems do not misuse drugs and have no drug-related problems. We feel that the alcohol problems of those

people with concomitant drug problems is commonly overlooked within drug-specific agencies, but even if these problems were addressed, this would still not address the majority of people with alcohol problems or dependence.

Without a specific strategy, alcohol provision and services will not get the attention it needs. This question asks whether there is a need for guidance for commissioners of local treatment services. We believe that there is such a need, and probably for something stronger than 'guidance': something akin to Models of Care in the drugs field, with clear targets for achieving the range of care expected, and clear funding sources so that these services can be developed and provided,

As part of this, access needs to be simplified, i.e. core assessment of patients/people presenting at any point, open and integrated pathways for care. Currently locally there is no such structure although non-statutory and statutory alcohol services communicate well, a major issue is the lack of coordination with general medical and surgical services. Many patients therefore do not receive appropriate support nor are they made aware of the services available to them.

20. We can learn a great deal from the developments in drug services over the past 20 years.
- Services and organisations with commissioning responsibilities do not naturally work together: different services need to be pushed to work together, to commission jointly, and to pool budgets.
 - Many people with problems are hidden from view, and outreach and better access to services is needed to enable them to reach help.
 - These outreach and more open access services need to be adequately funded.
 - A full range of interventions and treatments need to be commissioned, including in-patient care for assessment of complex needs, for detoxification of patients who are at severe risk from medical complications or whose social situation makes community detoxification unsafe, or for those with co-morbid alcohol and mental health problems.

Hence our conclusion from looking at the development of drugs services is that harm from alcohol is often hidden. Without a strategy nothing will happen. There are major resource issues that need to be addressed.

21. Work has been done regarding introducing non-breakable glass. Training needs to be focused on recognising and dealing with alcohol related problems. Increased training is required for A&E staff in identification of alcohol problems with delivery of brief interventions with the aim of reducing re-attendance at A&E with further alcohol related accidents [as has been done in only one of our local hospitals]. Work is needed around de-stigmatisation of alcohol misuse and dependence. Work needs to be done with Occupational Health Physicians and in the work place such that alcohol misuse / dependence is not ignored and the person allowed to keep working or is sacked or 'let go', perpetuating their problems. Education is needed to let people know that treatment is available and can be effective. Better policies are needed.
22. There are very strong links between alcohol misuse and mental health problems. We are sure the assessors are aware of the main documents relating to this (eg Abdulrahim, 2001; Crawford & Crome, 2001). These links are also embedded as part of the National Strategic Framework for Mental Health although not explicitly mentioned. This NSF has had an immense impact on planning of services and due to the lack of explicit linkage, addiction has not been given a high enough priority within developing Mental Health Services. Currently dual disorder services are still in the planning stage in many areas of the country. It has been difficult to set these up effectively. Patients with a dual disorder are often marginalised or not seen within the remit of a general adult psychiatric service thus creating greater problems.

Increased education and training of all mental health workers would help address some of these issues. See also 'Dual Diagnosis Good Practice Guide'(DOH 2002), Alcohol Concern : Briefing on dual diagnosis and alcohol.

Crime, disorder and anti-social behaviour: the effects on our surroundings and community.

Questions 23-28 : no comment

- 29 Yes. This should be encouraged and supported. A good example would be the development of Alcohol Arrest Referral Schemes that could be closely modelled on the drug referral schemes. However this should not be the only focus of increasing service provision.
- 30 These should not be targeted only at young people

Questions 30-31 : no comment

34. It is our impression that when a person is caught drink/driving, there is not an effective process to assess whether they are dependent on alcohol or have serious alcohol problems. We are aware of patients with alcohol dependence who have paid to go on a course to get their license back sooner. This is however inappropriate: those individuals with alcohol dependence should have their license suspended for 1 year [current DVLA guidelines]. We suggest that those caught drink/driving should undergo assessment as to whether they are dependent and then receive appropriate help. This may prevent people from recurrently losing their license and reduce tragedies on the road.

We also think that consideration should be given to setting drink/drive limits dependent on age and experience. This highlights again the need for education. We agree that the drink/drive limit should be further reduced.

The implications for vulnerable groups.

36. We see that all children and young people can be vulnerable both directly and indirectly through alcohol misuse. Services available to support children and young people are generally aimed at those who have directly suffered from the consequences of alcohol misuse and are very restricted. This should be addressed and this may prevent perpetuation of people misusing alcohol in several generations within one family.

We are also of the opinion that poor role models exist for young people regarding alcohol use. It seems apparent that becoming drunk is not seen as a negative consequence but often is a rite of passage.

37. Everybody either directly or indirectly is at risk and vulnerable to the harmful effects of alcohol.
38. We feel that an integrated assessment of hierarchy of needs is required. Engagement of vulnerable people should be made a priority. Risk should influence priorities. It is obvious that complex problems have complex solutions that will involve many different agencies and services. Clearly, in some models, tolerance to drinking is needed e.g. damp or wet houses, achieving more of a minimising strategy than absolute abstinence. Many of these people need to be worked with for many years, albeit sometimes slowly in a stepwise fashion to reach a more healthy way of living. Services are generally under such pressure that such long-term work is often prohibitive.

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Many people who work with patients with dual disorder, tolerate high levels of alcohol misuse in their clients; but many clinicians and workers fail to recognise that even small amounts of alcohol may be problematic for people with psychotic symptoms or other serious mental health difficulties. All the factors making up a complex problem should have interventions aimed at them. To do this would again involve a multi-agency and multi-disciplinary approach.

39. Many non-statutory and statutory services work closely together in partnership but also compete for funding. This is not always conducive to a good working relationship. We believe strongly in partnerships and recognise each other's skills. Strategic planning is absent in many cases and should be addressed. In addition, as mentioned, local liaison with those addressing physical needs of patients is very poor. This again would improve by having an alcohol strategy implemented locally. Many of these are due to historic boundaries in health and social care service provision and the resulting lack of common training for statutory and non-statutory sectors that could be addressed.
40. For those that are most vulnerable and therefore are more often chaotic in lifestyle, services need to be more flexible and accessible. A range of services should be available. Clearly, more education and training is required. Generally alcohol provision to this group is woefully inadequate.

AWP has no comments on the remaining questions 41 –61.