

## **RACING TO GET IN UNDER THE WIRE.....**

Personal circumstances have made it very difficult for me to do any serious work for some time, and I realise my contribution is very much of the 11<sup>th</sup> hour. Also, I'm sure that many more eminent and erudite than I have said most of the things which will inform best practice in the future. And yet, I cannot resist sketching in a few of the ideas I have come upon over the past ten years, just in case there is an opportunity to influence policy and more importantly practice on the ground.

### **National Alcohol Harm Reduction Strategy**

#### **Question 6 *How do you define alcohol misuse.....?***

There are two broad answers to this question. The first is that any use of alcohol which leads to short or long-term harm occurring to the drinker or to anyone else as a result of the drinking, then that is *misuse*. Harm can be organised into such categories as medical, social, relationship, financial, criminal justice etc., etc., but often in training sessions I find it more useful to divide harm into three areas: that which derives from inebriation, that which accrues to longer-term overindulgence, and that which relates to *dependence*.

The second answer is: What does it matter how I define alcohol misuse? Who do I think I am? The question drives me wild !! There are internationally recognised definitions of alcohol abuse and alcohol dependence (WHO and American Psychiatric Association) which serve in many parts of the world as standards by which people (clients, patients) are diagnosed, treated and referred according to objective criteria. Having used these standards for many years, I am impressed not only by their acumen and the clarity and instruction they bring, but by their clinical significance, which cannot be underestimated not just in medical terms, but with regard to domestic violence, child protection and criminal justice disposals. "Misuse" then, is a generic term which includes the harm resulting from isolated occasions of drunkenness, plus the categories of "abuse" and "dependence" which are internationally defined as a result of extensive research by eminent experts in the field.

#### **Question 7 *What drinking patterns should an alcohol strategy seek to affect...?***

A National Strategy should seek to affect all drinking patterns – to inform the whole population, including those who drink and those who don't but who may be put at risk at any time by those who do. Preventive work in terms of education and information needs to be done with children and with adults currently drinking sensibly. It needs to be done with those who are causing harm through inebriation, and it needs to be done with "Abusers" (see above) and "Dependent" people. The point is, intervention works, and early intervention works best.

Resources need to be invested in *effective* education programmes. How many times have I heard "Yes we have a good record of alcohol education;

we have lots of provision in our schools” ? Never mind the quality, feel the width? There are **key messages** which must be consistently put over. (One of which is that **anyone** who indulges in prolonged heavy drinking risks becoming *dependent*, and thus risks losing the privilege of being able to indulge in the occasional social drink, another is that one doesn't need to be *dependent* to die of cirrhosis of the liver, one of which is that 50% of pregnancies in this country are unplanned, and the foetus is most susceptible to harm in the earliest weeks when the mother may not realise she is pregnant – there are, of course, several others!).

Resources need to be put into preventive work with risky drinkers in Primary Care settings (i.e. the Brief Interventions agenda). Care needs to be taken to ensure that effective interventions for women in this category are researched..

Resources need to be put into Intensive Structured Programmes of Psychotherapy to address “Psychological Dependence.” Currently these are few and far between, they are mostly 12 Step programmes, and many are inaccessible to ordinary people because of prohibitive cost or waiting times to admission. (Also, Admissions Criteria are not standardised, so there is a post code lottery not only by provision, but by qualification. This, at least, could be solved using the internationally recognised definitions of dependence).

Intensive structured programmes of Psychotherapy to address Psychological Dependence need to be introduced into all prisons. Currently, because intake of prisoners is often from many different PCT or even SHA areas, some prisoners can access treatment on release and their former cell-mates cannot. This inequity could be solved by having “in-house” programmes, and this would also mitigate against the common occurrence of dependent drinkers gravitating to the nearest hostelry immediately on release.

**Question 8 *Is there are relationship between trends in drinking and wider social changes.....?*** Of course. Wider employment opportunities and social freedom for women, integration of “immigrant” populations from previously abstinent cultures plus all those mentioned. We need to focus on those with increased biological susceptibility – women and some ethnic minorities – and we need to focus on informing potential “significant others” to protect them from becoming “victims” of all sorts of social and psychological ills.

**Question 9 *Are there groups we should be focussing on.....?***

I am concerned about the parlous state of advice and information for pregnant mothers, particularly from ethnic minority populations. It seems to me that “advice” derived from studies of mainly white affluent non-smoking populations is promulgated as universally applicable to women from different ethnic, social and economic backgrounds. What information do we have about the effects of drinking in pregnancy amongst south-east Asian populations, where one or both of the genes which process acetaldehyde is absent, either in the mother or the foetus? What are we blundering about at? (The advice published by MIDIRS is particularly worrying).

**Question 13 *How do attitudes to risk affect the use of alcohol?***

*And vice versa?* Decreased serotonin levels caused by the ingestion of alcohol impair normal impulse control mechanisms. This is not rocket science, and psychometric testing can evidence decline in impulse control problems once abstinence is instated. The answer to the question is far from obvious, and depends also on what you mean by “use”. There are crucial implications here for the criminal justice system.

**Question 14 *How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become harmful drinking?***

I think “heavy drinking” is normally defined in the literature as 35 units per week for a woman and 50 upw for a man. It must, by definition, be harmful drinking, as this level of consumption is well above that necessary to lead to cirrhosis, for example. Heavy drinking causes a plethora of medical risks, is likely to put a financial burden on families, may disrupt relationships because of this and mood swings – it is already harmful, surely?

**Question 17 *What, in your opinion, are the most appropriate forms of prevention of alcohol dependence.....?***

Please see previous answer to Q7, above. Training for professionals needs to include a focus on their own psychology – Sprately and Cartwright’s work on why professionals don’t intervene, for example. The crucial distinction between “Abuse” and “Dependence” and its implications needs to be communicated, together with the social implications it implies. For example, if a Social Worker has to decide whether or not it is safe to return a child to a parent with an alcohol problem, and the parent is a dependent drinker (according to DSM IV criteria), then the parent has, by definition lost control of their ability to limit the onset, termination or level of consumption of alcohol. If the parent has not committed to permanent abstinence and undergone a programme of successful abstinence-based treatment, it is not safe to return the child. If the parent is classified as having “Alcohol Abuse Disorder” (DSM IV), then an intervention consisting of motivational work, advice and intervention is likely to have the desired effect on drinking and parenting behaviour. Given that irrational prioritising of normal life concerns is a feature of dependence (DSM IV), it becomes much simpler to gauge the safety issues.

**Question 18. *Brief Interventions.....?***

BIs are reckoned to be most effective with non-help seeking populations of risky (i.e. non-dependent) drinkers, and not very effective with women (possibly because those (abusers) who still can, already have controlled their consumption). What surprises me, is the way that they are put forward as a universal panacea in the Governments “Models of Care” draft policy document. I think potentially it is very easy to identify those at risk, through screening in Primary Care. Currently though, PCTs have no targets to meet.

**Question 19 *Do current treatments for alcohol dependence and hazardous drinking work.....?***

I am concerned that “dependence” and “hazardous drinking” are lumped together in this way. I trust there is no implication that these two terms are synonymous? What I think it means is alcohol dependence and alcohol abuse – which are very different animals.

I believe that current treatments for alcohol dependence do work, provided that they form part of a programme of timely and coherent care. One of the most successful schemes of intervention I have been party to, was where patients being treated in Gastro-enterology Departments of a local hospital, were detoxified whilst they were in-patients, referred to a local non-statutory service for Alcohol Assessment which was carried out in hospital prior to their discharge, and referred into an intensive structured treatment programme of 7 weeks’ duration to address the psychological dependency to which they were transferred on the day of discharge.

I should like to see more **non** Minnesota Model programmes of intensive abstinence-based structured psychotherapy, and more emphasis on the benefits of abstinence for dependent drinkers. I do think commissioners need guidance. I think many of them haven’t got a clue about the nature of services, or the underlying philosophies which “inform” and shape them.

Individuals should be able to knock on the door of any provider in any locality, receive a standardised assessment and be referred without delay to the service which best meets their needs, according to published referral and admissions criteria. There should be as little delay as possible between help-seeking and intervention.

A crucial factor, which is rarely mentioned is goal-setting. One of the functions of Assessment is surely to devise a Care Plan and set goals for the intervention. When Alice asks the marmalade cat which direction she should go in, he replies, as I recall, that this depends very much on where she wants to go. If there is not clear goal, there can be no proper evaluation, and client, provider and commissioner are all working in the dark. The client needs to know whether he or she should pursue a goal of abstinence, or whether, in the long-term, they are likely to be able to return to a pattern of unproblematic usage.

Given the internal ambivalence which characterises substance misuse, it is crucially important that practitioners give a clear opinion and guidance on this. In my view their practice is unethical if they do not. This chimes in with the guidance issued by the Clinical Negligence Scheme for Trusts to all NHS Trusts, Standard 5, regarding the ethics of telling the patient both what they want to know, and what they **ought** to know. The skill of the practitioner is in conveying this message in a way which liberates, motivates and inspires. This is the antithesis of the oft repeated mantra that you have to wait until the client decides to change. No-one makes decisions in a social and intellectual vacuum, and clients who fulfil criteria for a designation of Alcohol Dependence Disorder according to DSM IV criteria, who are not advised that they are unlikely, in the long term, to be able to control their drinking at low and unproblematic levels over time, may in ten years time come back to sue their Assessors.

Too often I have experienced a situation where an Assessment has been carried out and a Care Plan directed at abstinence generated by one provider, but when the client has been referred to another service provider for a necessary step in the intervention, that provider has encouraged the client to change their goal. “*You don’t really want to give up drinking, do you? Why not join our “controlled drinkers” group?*” Too often I have seen the disastrous consequences of this for the client. Different treatment philosophies have real consequences! I don’t think the commissioners understand this. Also, I think individual Consultant Psychiatrists heading up NHS specialist teams have enormous power and influence, and the commissioners of their services are over-awed by them.

**Question 22 *What are the links between alcohol misuse and mental health problems.....?***

This is a large question, and I’m sure it has been well covered by others. I should just like to emphasise that a failure to appreciate alcohol as a *depressant* drug appears to be widespread. I have encountered many patients of psychiatrists who say they have never been asked about their alcohol consumption, some clients who have been referred to “anxiety or depression management” courses by GPs, where plainly the presenting need was for detoxification, and many generic counsellors who have no idea of the relationship between alcohol and depression, nor how to assess or refer. It frightens me.

**Question 23 *What evidence is there about the links between alcohol and crime....?***

I think John Jacobs research (Report available from Alcohol Concern) regarding the links between substance misuse and domestic violence is very instructive. There are perhaps a couple of things he omits. One is the “Othello syndrome” – where the male drinker becomes impotent and then imagines his female partner’s needs must be being satisfied by someone else – leading to intense jealousy and attempts to prevent the partner from going out or contacting others. The other derives from verbal reports from male clients, to the effect that they deliberately pick fights with their partners in order to gain an excuse to leave the house (and drink). “Now look what you made me do! I need to go to the Dog and Bucket to get some peace”.

My other concern is that again the distinction between Abuse and Dependence can inform effective criminal justice disposals. If a dependent drinker has a history of offending, and on examination all the offences are alcohol-related, there is evidence that removing the dependency (i.e. restoring normal behavioural control through abstinence) can, by and of itself, resolve the problem. Relevant psychometric testing can add to the sharpness of the evaluation by discriminating between those who appear no more likely than the average person to have a history of offending, and those who show some predisposition to criminality, which is independent of their substance misuse.

**Question 24 *Is alcohol a factor in habitual re-offending?***

For a high proportion of **dependent** drinkers, yes – see answer to 23 above.

**Question 25 *To what extent can alcohol convincingly be demonstrated to be a factor in criminal and disorderly behaviour....?***

The evidence we should look at relates to the effects of alcohol on various centres of the brain and hence behaviour, the evidence of the aggressivity which accompanies withdrawal from physical dependence to be found on de-tox wards and in the literature, and I believe there are some animal studies? While it is probably true that perceptions of alcohol as an agent provocative of aggression fuel both the debate and to some extent the anti-social behaviour, these perceptions inform both the perpetrators and the agents of the law – so how important is the question?

In terms of Domestic Violence, the traditional argument suggests that men use alcohol as an excuse for violent behaviour, and that alcohol is therefore a red herring and should be ignored. I believe this is an unhelpful way of looking at the equation. Alcohol does no harm to anyone. I have several bottles of very strong stuff on a shelf in my kitchen, and it has done no harm to anyone. The point is, if a man knows that under the influence of alcohol he commits acts of Domestic Violence, then he should choose not to drink. If he hesitates, he is probably alcohol dependent (loss of control, irrational life prioritising). If he refuses abstinence-based treatment, he is declaring that alcohol is more important to him than the safety and welfare of the woman he “loves”. In this case, the woman concerned (i.e. all persons subject to substance-related domestic violence) should be supplied with information about alcohol dependence and its implications, so that she can make an informed choice about whether or not to leave. Then, from a position of safety, she can decide whether or not to countenance any resumption of the relationship, but make this contingent on compliance with abstinence-based treatment. This approach increases the likelihood that the man will seek treatment, and not just transfer his “affections” to his next victim.

**Question 35 *What is the nature of the link between alcohol and domestic violence...?***

Please see answers to questions 23, 24 & 25 above. Also:

- drunkenness leads to loss of anxiety, loss of judgement, reasoning, loss of temporal awareness and a slight paranoia. Typical manifestations of the latter are a suggestion that someone is impugning the man’s honour – “Are you calling me a so and so? Are you looking at my woman?” These effects can make misunderstandings more likely – misinterpretation of visual cues, tones of voice, loss of fear of tomorrow’s consequences of today’s actions.
- Anger management courses are unlikely to succeed if the man has an alcohol problem. Such men have been shown to be less likely to complete the course. Also state-dependent learning (the tendency of a person properly to recall what they learned when sober only when sober and vice versa) means that a man under the influence of alcohol is unlikely to remember what he learned on an anger management course, let alone put it into practice!

- Social factors lead to aggression. Money spent on drink instead of children's shoes, failure to perform agreed household functions like collecting children from school – these sorts of behaviours are likely to cause conflict, and redress is likely to be sought at the earliest opportunity following the offence – when the man returns from the Dog & Bucket and is under the influence (see above).
- With a *dependent* drinker, the compulsion to drink may be incomprehensible to their non-dependent partner, and this, in itself can lead to conflict. “Why do you **have** to go to the pub? It's our daughter's birthday!”
- With physically dependent drinkers, fear of withdrawal may be intense, and the drinker will stop at nothing to obtain their next fix, and will not take kindly to attempts to prevent this.
- Unmedicated withdrawal from physical dependence can cause extreme irritability and oppositional behaviour. Sometimes there are visual or auditory hallucinations, and the drinker will attempt to “defend himself” from these phantoms.
- A very tolerant drinker may appear to be sober, when in fact they are not. Social Workers and Probation Officers need to know this!
- Short-term memory loss may mean that the drinker genuinely does not remember how they behaved the night before – and may not understand why the spouse is angry with them. This can also cause disagreements.
- Alcohol ingestion can cause or exacerbate the effects of mental illness. Statistically people who are in drink and have a mental illness are more likely to be violent than an average population.
- As Shakespeare said, “alcohol provokes the desire but takes away the performance”. The man may blame the woman for his impotence and take out his sexual frustration on her. (I have anecdotal evidence of this).
- There is a statistical association between alcohol and all forms of violence.

I believe we could be much more effective in addressing alcohol-related Domestic Violence if these associations were recognised. The purist “feminist” view is, I think, often self-serving and counter-productive. We could do much effective work both with drinkers and those on the receiving end of the violent behaviour.

**Question 36 Which children / young people do you think are the most vulnerable to the consequences of alcohol misuse?**

As Significant Others – those who live with people who are violent, inconsistent in their parenting, model irrational behaviour or neglectful.

As drinkers, those who are victims of inadvertent alcohol poisoning – the “Sunday morning syndrome”, where open bottles of alcohol (alco-pops?) are left on the table by the adults after the Saturday night party. Also, those young people who drink within their peer group in an unsupervised environment, and whose parents are not focussed on their care, plus those whose parents model irresponsible attitudes and behaviour to drinking.

We need to look hard at the alco-pops issue, and to the advertising of alcohol to young people.

**Question 37 *What other groups are particularly at risk...?***

Those whose parents were new immigrants to this country, and come from an abstinent culture.

Also, homeless young people. These are often offered hostel accommodation alongside older “hardened” drinkers, and may adopt entrenched drinking patterns. They need to be separated and be given an intervention at the earliest opportunity.

**Question 43 *How well is the sensible drinking message reaching its audience.....?***

Superficially it seems to be relatively well known amongst younger people and health professionals, but if you scratch beneath the surface you find that very few people really know what a unit is. Given the metric / imperial dichotomy, the range of glass and bottle sizes and the range of ABVs out there even within drink categories, this is hardly surprising. The only real solution is bottle labelling.

Is it clear? Well, it seems to me that it's not that long since bulk standard HEA messages which derived largely from studies of men were foisted as whole population advice on to everyone else. How many women know that Post-Menopausal women taking HRT are at increased risk of developing breast cancer even if they keep their drinking within DOH maximum recommended sensible limits? I think people are more sophisticated than the Government gives them credit for, and partial or conflicting health messages lead to a distrust of what is seen to be “propaganda”. This can be and is to my certain knowledge counterproductive.

**Question 44 *How well is scientific research feeding into alcohol education.....?***

See 43 above. Not as well as it might be! Who is there to mediate this information? Academics research, treatment providers provide, and the HEA seems to regurgitate ancient wisdoms. Adventurous treatment providers try to innovate, but commissioners don't understand what they are commissioning. (Am I too gloomy?!) (Why did no-one else produce leaflets aimed specifically at male drinkers, after the shock publication of New Scientist a few years

ago?) How about local hospital liver units publicising the increase in cirrhosis rates amongst different sectors of the local population?

**Question 46 *What is the role of schools, colleges.....?***

Potentially huge. Please see Q7, with regard to key messages. There is scope for concerted approaches in centres of higher learning where there are on-site counselling services. Here you have opportunity to integrate education with employment law and medical and social interventions. A lot of alcohol strategic planning seems to me to be very akin to good parenting behaviour.

**Question 47 *Role of families.....?***

Again, potentially huge. We could benefit perhaps from looking at Italy and learning how Italian family life shapes attitudes to alcohol consumption.

**Question 52 *What is the relation between the creation of fashion and trends.....?***

This may be a bit facile and doesn't really address the issue, but it is instructive to look at the way manufacturers advertise their products – using sexual attractiveness, social acceptance, machismo and power – and to show the real effects of alcohol on these attributes.

**Question 58 *Who should be responsible for costs.....?***

I think within the criminal justice system, apportioning costs to perpetrators could be salutary, although difficult to implement with men of straw. In principle it seems right not to protect people from the (financial and other) consequences of their own behaviour. It does seem entirely reasonable that a small levy should be placed with the drinks manufacturers, whose profits seem massive, particularly when set against the derisory monies available to the alcohol problems service providers.

**Question 61 *Are there particularly effective workplace-based initiatives.....?***

Again, the Abuse / Dependence distinction can inform greatly workforce interventions. Those who are Abusers, who could cut down and drink in an unproblematic way if they chose to, are likely to respond quickly to advice, information, reprimand and a view of the potential consequences. Those who are Dependent, and who are less likely to admit to a problem, can be faced with a “tough” decision – either the matter will go to discipline, or, if there is any possibility that the problem could be alcohol-related, the employer is very happy, keen and supportive of the idea of the employee having an Assessment, and if Dependence is found, of affording the employee the time to undergo the treatment they need. This often creates a win / win situation, where the employer gets back a functional effective worker, and the employee doesn't slide into a downward spiral of job loss, family disruption, housing loss etc. It may seem over-simplistic to the academic ear, but on the ground the Abuse / Dependence distinction offers solutions!

**Please see also Dr Norman Hoffman's articles on the clinical significance of the Abuse / Dependence dichotomy in the August and September 2002 issues of Addiction Today.**

Yours in haste

Mary Longley, former Head of Client Services, Alcohol Problems Advisory Service