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SU / DoH Consultation,
Room 4.6,
Admiralty Arch,
The Mall,
London SW1A 2WH

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Dear Sir / Madam,

National Alcohol Harm Reduction Strategy

We welcome the opportunity of responding to the government's consultation document on this important topic, and look forward to contributing further to the development of the strategy.

St Mungo's is London's leading provider of residential and support services to men and women who are homeless and vulnerable. Notwithstanding the growing prevalence of drugs, alcohol misuse and dependency are still a significant feature of our client-group. Our hostels and housing projects are concentrated in the 6 inner London boroughs, whereas our non-residential support programmes (e.g. outreach / resettlement / employment and training / specialist health work) have a pan-London remit. Our comments on this strategy thus arise from our particular perspective.

Our comments are therefore as follows:

- We do not find the structure of the document very coherent. It is claimed in the *Foreword* that the strategy will offer three things (how to identify / prevent alcohol misuse; help; and manage the consequences), but the structure which follows does not reflect these goals at all. There is, for example, no emphasis on the services which are needed to tackle alcohol misuse.
- It is also a revealing oversight to have equated "the consequences (of alcohol misuse)" with "disorder and anti-social behaviour", when arguably the most important consequences are damaged families and the kind of social breakdown which is becoming all too common.
- In the *Introduction* you list the "key organisations" which government will have to involve. We are surprised that you have omitted the retailers, including pubs, since they are in an especially strong position to influence anti-social behaviour by limiting consumption.

Turning to the main body of the text:

1. Principles underpinning the strategy

- We would like to see a strong statement about where responsibility for implementation lies. Throughout the document there is reference to “Government intervention”, but we assume that in practice any interventions will be implemented by local authorities. This needs to be clarified, along with the practical steps which will be taken to ensure that local authorities do indeed operate within a national policy framework rather than outside.
- The draft is completely silent about the range and kind of services which are necessary to achieve harm reduction, and particularly the necessary range of housing. No matter how ‘robust’ and ‘rigorous’ is the thinking which goes into the strategy, it will be worthless if it does not address head-on how to improve existing services. Examples of the kinds of service which our experience makes clear are necessary are set out below:

- i) **Wet Day Centres** It has been proven that we are able to do more work with clients when they are inside, rather than on the streets. It is also true that drinkers are more vulnerable on the streets and more likely to suffer poor health, as well as being at greater risk of becoming involved in the Criminal Justice System. Drinking schools are also seen as a nuisance in the community, and yet efforts to bring drinkers indoors are hampered because they are often excluded from day centres as a matter of organisational policy.

Wet day centres offer a way through these contradictions. St Mungo's has done more than any other homelessness agency to pilot the relaxation of “no drinking” rules in residential settings, and we are keen to extend this to non-residential ones – but we do need clear funding to enable us to progress it.

- ii) **Residential Care Wet Provision** – There are real problems with the attitudes of commissioners towards people who are continuing drinkers. A lack of commitment on the client's behalf to embrace abstinence justifies the commissioner in their view that funding should be limited. Over the past 5 years we have seen a dwindling commitment to wet residential care in terms of either the closing down of homes for clients who continue to drink or a change in the funding stream which has decreased the ‘care element’ provided. We would like to see money from the local DA(A)T as well as Social Services ‘ring-fenced’ for this provision.

As Social Services departments come under increased funding pressures, they displace those pressures on to providers. It is not possible for providers to offer higher and higher levels of care for less and less money – sooner or later something will have to give, and the person who is most at risk is the vulnerable client.

- iii) **Pre-detox Support:** We would like to see more emphasis on preparing clients for treatment. If someone is more aware of what s/he is to expect from a process, they are more likely to succeed.
- iv) **After-Care Support:** It is essential that there is more money made available for post-treatment support. This is then when the majority of

clients are liable to relapse. This support should be available where people live, and not just 'off-site'.

- v) **Existing Alcohol Services:** need to be more flexible with their appointment systems. At present, this is too rigid which then excludes many homeless people.
- vi) **Skilled workers:** We would like to see a greater 'skilling-up' of drug workers so as to enable them to work with drinkers. Many of our residents are poly-substance users; alcohol is often used by chaotic drug users and vice versa. However, services are still very separated. This is not meeting the needs of our clients. It is important to remember that alcohol is implicated in many drug-related deaths.
- vii) **Mental Health services:** There needs to be better access to mental health services. At present, it is difficult to get someone who is drinking linked in with Mental Health Services whilst they are still drinking. The result of this is that many of the most vulnerable clients with multi-needs are actually more likely than any others to 'fall through the net'. We would like to see more 'joined up work' between Social Services departments and mental health and alcohol services.

2. The cultural and behavioural dimension to alcohol use

There is an English tradition of excessive drinking. It was the English who developed the vineyards of Bordeaux and Champagne, and who set up and sustained the port and sherry industries, at the same time as the urban poor were consoling themselves with cheap gin.

Excessive drinking is, though, not necessarily the same thing as problem drinking (which is well represented across the whole of Britain), nor the same thing as irresponsible drinking (which seems to be much more the thrust of this paper, and which probably is more of an English phenomenon).

Public drunkenness is more common in Britain than in the rest of Europe, and also seems to be more socially acceptable here. The problem is that boundaries about what constitutes acceptable behaviour have come down

For obvious reasons, service user involvement in alcohol programmes is relatively un-developed, but we think it is crucial that their views should be sought and incorporated into practice and policy.

3. Health aspects

- i) With a range of different strategies and programmes aimed at increasing social inclusion, it is important that strategies are joined up at both a national and local level. Any national alcohol strategy needs to be closely linked to local homelessness and Supporting People strategies, as well as to Health Improvement plans which tackle health inequalities.
- ii) Often homeless drinkers will find that they will have to go through up to four separate assessments before they are able to access the service/treatment they want. This can be both frustrating for them and

also very intrusive. Quite often clients will lie or avoid giving too much information as they are unsure where it is all going, which is the precursor to lack of commitment and relapse. We would like to see the adoption of a Common Assessment Tool that crosses voluntary and statutory sectors.

- iii) It is extremely important that agencies helping alcohol dependents should be clear that people do not have right to drink themselves to death or into extreme ill health. Harm reduction has to start from this basis, and also to proclaim this conviction.
- iv) The assumption in this paper that all treatments are funded by the NHS is flawed. Placements which offer detox / rehab / counselling are funded by local authorities in social care programmes. The problem is that the financial position of local authorities in London is so threadbare that these packages only last for 3 to 6 months, whereas for our client group a much longer period is needed. Indeed it is noticeable that the longer the intervention, the longer-lasting the result.

We are disappointed that the value of “containment” is not recognised. We have much experience of working with long-term street-drinkers, for whom abstinence is a completely unrealistic goal. Containing them within a tolerant regime which places pressure on them at their pace is the best hope for achieving “harm minimisation” in terms of their physical health and their social functioning.

4. Crime and anti-social behaviour

We would like to see arrest-referral schemes for homeless people which would see them, on being charged or on conviction, referred to an Alcohol Advice Service, with a treatment option.

5. Implications for vulnerable groups

- i) Research shows very clearly that getting an alcohol assessment and access to rehabilitation for a homeless person takes far too long, and a key access threshold for treatment is that the person should be “motivated to change” – which is a bureaucratic, pseudo-psychological way of denying access to services to those least able to make their case. What is needed is rapid access to assessment and treatment in order to maximise the success rate. It needs to be available at the point when the client is motivated to do something about their drinking. If people have to wait for too long, they lose their motivation, and when the appointment comes along they are disinclined to attend.
- ii) Funding for alcohol services is poor and often only short-term. It would seem that ‘motivation to change’, meaning sobriety in some local authorities, is used as a way of rationing scarce services. Drug Action Teams (DATs) cover most of the country, but there are only a small number of Drug and Alcohol Teams (DAATS). This is because funding for drugs is widely available in these areas, but little or no funding for alcohol.

Funding for alcohol treatment should be drastically increased to reflect that fact that addiction to alcohol kills many more people annually than addiction to other drugs.

Alcohol commissioning should be integrated with drug commissioning through DAATS.

- iii) Alcohol consumption is usually a spur to social connection, but for vulnerable people it is too often an indicator of social isolation. Medical treatment has to go hand-in-hand with more general counselling which addresses the reasons why people drink problematically.

6. Market dynamics

We think that Government should consider placing health warnings on alcoholic drinks over a certain strength (say, 20%).

Soft drinks should be available more cheaply in pubs, clubs and restaurants.

Alcopops are an example of very successful marketing which introduces alcohol to younger people. This kind of marketing should be carefully regulated.

7. Cost / benefits of alcohol consumption

Several years ago it was stated that the alcohol industry employed (in breweries, distilleries, off licences and pubs) c. 600,000 people – and that c. 600,000 people in the country had an alcohol problem. This illustrates rather clearly a correlation between cost and benefit.

In recognising the enjoyment that many people derive from alcohol, and the fact that adults are capable of making their own decision without excessive guidance from government, it is still important that steps are taken to reduce the undoubted damage caused by problem-drinking.

We hope the above is helpful, and look forward to contributing our thoughts as the strategy evolves.

Yours sincerely,

Charles Fraser

Chief Executive