Bolton Salford and Trafford Mental Health Partnership NHS

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NATIONAL ALCOHOL HARM REDUCTION STRATEGY

CONSULTATION DOCUMENT

This is a response to the consultation document which has been considered by Bolton Substance Misuse Service,Salford Alcohol Service,Trafford Substance Misuse Service and Wentworth House Inpatient Alcohol Treatment Unit as part of Bolton,Salford and Trafford Mental Health Partnership.

Our comments are grouped under the eight major themes listed in the document as opposed to a specific response to all 61 questions.

We have attempted to express a consensus viewpoint whilst recognising that in relation to certain questions there is significant variants in personal views and opinions. As a Mental Health Partnership we have a special interest in the provision of secondary and tertiary services and clients accessing these. We would also like to emphasise the following points, although we are aware of the impact of alcohol on crime and young people, there are a number of strategies focusing on these issues. We are particularly concerned that the health issues particularly in relation to treatment and dual diagnosis receive sufficient focus in the Strategy.

However this strategy consultation document is a very welcome step in the future direction of alcohol policy.

1 The principles that should underpin the Strategy (Questions 1 – 5)

Drinking is a key part of our society and consequently the government is already involved in relation to the impact of alcohol on NHS, police and education. The Young Person Substance Misuse Plan already incorporates alcohol and tobacco.

Its involvement is also linked directly to the revenue it receives from taxation.

As in any risky behaviour, individuals do have choices i.e. speeding, smoking, sex, but the impact of this behaviour can be much wider in relation to public health and community safety and this is where the Government has a responsibility to intervene. The strategies to intervene can be numerous for example enforcement in relation to drink driving.

Individuals, however, need to be able to make informed choices and can only do this with the right information told to them consistently and clear, as in smoking.

We feel that when people do get into difficulties and develop problems it is essential that a range of comprehensive and accessible services are available as suggested in the 'Models of Care' document.

We clearly need a partnership approach to the Strategy, involving various agencies, including licensing, police, transport as well as health and social services.

Strategy should encompass principles of prevention and education, harm reduction, public health and community safety and individual treatment variety of interventions are required at different

stages of peoples drinking e.g. a binge drinker will require a different response to a dependant drinker.

2 The Cultural and Behavioural Issues and Alcohol Use and Misuse (questions 6-13)

There are a number of useful definitions, which can be employed for alcohol misuse. A simple one which is useful with clients is 'If **It causing problems to you or anyone else' e.g.problems to health and social functioning.**

Categories of hazardous, harmful and dependent drinking are useful as are the '**the use of sensible limits'.**

A National Strategy should seek to focus on the patterns of drinking defined by the WHO of Hazardous and Harmful and Dependent Drinking.It is important to recognise there are degrees of severity within each of these broad categories of hazardous, harmful and dependent drinking.

Treatment for dependence is also effective including social skills training, motivational interventions, cognitive behavioural approaches, acupuncture and medication.

Prevention should concentrate upon young people and public information including campaigns and unit labelling.

Advertising practice needs to be examined, particularly in relation to young people and the association with sports and other healthy activities to ensure we are not giving conflicting messages.

Wider social changes which have affected drinking patterns include the increase independence, equality and autonomy of women in society. Women's drinking is mirroring men's drinking with the 'ladette' culture.

Due to delays in marriage and childbirth people remain single longer and patterns of peers drinking continue.

Gay culture is based mainly around pubs and clubs.

Increase in disposable income with certain groups has also had an influence on patterns of consumption. The relative costs of alcohol appears to have decreased and trends towards more 'at home' drinking encourages higher levels of consumption.

Attention needs to be focused on families and younger, single and professional people.

There are various high-risk groups where for various reasons there is a high level of alcohol consumption, which appears to be in relation to employment e.g., doctors, police, nurses and those employed in the licensing and catering trades.

Besides women there are others who require special attention who for various reasons may be more susceptible to harm as the problem may be concealed until the problems become extensive, impacting on physical, psychological and social well being. These groups include elderly people, pregnant women, or women trying to conceive, people with mental health problems and people from black and minority ethnic communities.
It is important to ensure there is also an outreach approach to engaging with minority ethnic groups, by establishing what issues have to be overcome, and identifying effective means of engagement with these hard to reach groups.

The positive aspects of alcohol are that it can assist relaxation and socialisation and in limited quantities it is seen to have certain medicinal and health benefits. We agree it is important to state the positives of alcohol, particularly to those people engaging in services who are working on alternative goals of abstinence.

If alcohol did not exist, our culture would be affected by the disappearance of the pub culture as we know it, as well as the keyrole it plays in most social, sports events and celebrations.

English drinking culture has changed significantly over recent years. Although still generally associated with pubs, there appears to be clear segregation in terms of towns, city pubs and suburban / rural pubs and the clientele of each.

City and town centre drinking is associated with binge drinking, 'lager louts', vertical volume drinkers and 'super' pubs and clubs.

Pubs, which tend to attract an older clientele are in decline or have converted to eating pubs. Drinking at home is now a well-established part of our culture.

Influences must include peers and family but the availability, cost and amount of disposable income are strong influences

Advertising and brand associations are important factors. Obviously brewers invest considerably in marketing campaigns.

Other campaigns with similar investment and marketing can be equally persuasive e g drink / driving. Groups of people respond positively to messages in relation to risk and there are particular high-risk areas e.g. mixing alcohol and medication, drugs, drink driving, unprotected sex.

3 Health : Prevention, Treatment and the Impact on the NHS (Questions 14 – 22)

Definition of harmful drinking as previously described in Section 1. Factors we would consider in assessing a change in drinking; are changes in pattern, increase in consumption, impacting on physical health, family, social, forensic, mental health and employment. As well as loss, control, craving, tolerance, inability to maintain abstinence and presence of withdrawal symptoms.

Education and information in relation to the effects of alcohol can enable people to make lifestyle changes, for example to ensure they keep their employment, partner or get back their driving licence.

Evidence in relation to health costs is clear. Alcohol Concern have many statistics e.g. mortality rate, A & E attendance etc and the evidence in relation to cost directly and in direct to the NHS.

However, significantly there are high levels of staff sickness in the NHS. Health staff are considered to be at high risk of misusing alcohol and a correlation may be worth considering. Further more it is apparently health staff who are assaulted more often than police now and further research into this and the relationship of alcohol on these incidents may impact on indirect costs.

The most appropriate means of preventing serious alcohol problems are early intervention and recognition of alcohol problems. Brief Interventions and motivational interviewing, education and information in relation to the effects of alcohol.

Increase cost of alcohol influences the consumption of alcohol.

Most health and social care staff report they receive very little training in relation to alcohol. There needs to be generic training and not just for health and social care staff but all agencies in contract with the public. This should include generic ward staff and community staffs, to ensure all workers are confident and trained in mainstream alcohol interventions and for nurses to be able to identify general health issues and for everyone to know about services and referral pathways.

Specifically, training in relation to alcohol education, brief interventions and motivational interviewing.

Brief interventions can be effective in those with less severe problems and the non-treatment seeking population but we still appear not to be reaching clients early enough. Risks still are not being identified; therefore, we need more effective ways of assessing and screening.

A broad range of services is needed for people suffering alcohol related problems. Early and brief interventions can help to prevent the development of more serious alcohol problems.

However, 1 in 25 people in Britain are dependent on alcohol. Thousands of people required specialist help either through counselling or more intensive residential treatment. Although in the last 10 years we have seen the development of Community Alcohol Teams many areas have very little provision based mainly on non-stat counselling services.

A Strategy needs to reflect the need for services in all 4 Tiers, and to ensure that a service development in one tier should not result in disinvestment in another tier unless there is a needs assessment in relation to demand.

Specialist services cannot provide all the support for all the problems. The Drugs Models Of Care document provides a useful model in terms of levels of interventions 1-4,and specialists services should focus on interventions for people in tiers 3 and 4.

Specialist treatment is required for those with the most severe alcohol problems and co-morbid problems. These are often complexed and longstanding issue e.g.childhood abuse.

It is often unrealistic and inappropriate to expect generalist to respond to this group.

Specialist services are needed for their high level of knowledge and expertise, to offer training, consultation and liaison to generalist staff.

With the reduction in the last 10 years of hospital beds, particularly in mental health services, access to in-patient detoxification has become increasingly difficult.

Most in-patient detoxes are provided on acute medical or mental health wards which can usually only be offered in crisis and feedback from clients and staff is that this is as been unsatisfactory for a number of reasons.

Howeverlocally in Bolton pre-admission planning meetings involving ward staff prior to inpatient admission for detoxification have proved to be effective in ensuring detox is part of a complete package of pre-admission and post admission support. This prevents crisis admissions and the subsequent failure in achieving stability, which is often associated with crisis detoxification.

Dual diagnosis patients are some of the most vulnerable in society with issues of self-harm, homelessness, poor physical health and offending. They can place excessive demands or overwhelm services unable to meet their needs or alternatively be excluded from services. There is evidence to support the combined and integrated care of this client group as provided by Wentworth House inpatient unit. This includes a comprehensive ongoing assessment a range of treatment interventions including detoxification, other pharmacological traeatments, cognitive behavioural group work, family involvement and Mutual Aid as well as aftercare

In most areas a range of specialist services is unavailable or limited particularly for those requiring treatment for complex needs. Limited facilities are available regionally and nationally. There are constant pressures in relation to funding and short-term views on service provision by local commissioners as well as the focus on activity rather than quality and outcomes. Research would indicate that the benefits of treatment exceed the cost of providing it. More research needs to take place but studies in America calculated for every $10,000 spent on treatment of alcohol problems $30,000 is saved in medical spending
As well as health cost benefits alcohol treatment can also reduce criminal activity; demands on social care and housing, added to these are also the benefits for the individual and their families.

Treatment for alcohol dependence is effective including detoxification, cognitive behavioural approaches, social skill training, and specialist prescribing including Antabuse and Campral, groupwork and acupuncture and family work.

Treatment needs to be provided as an integrated care package particularly in relation to complex needs. The best outcomes are when alcohol problems and other associated conditions are treated e.g. depression are treated simultaneously

Clients also value services provided by ex-users e.g. AA, counselling. Access to treatment has primarily been decided on motivation but often due to the extent and complexity of client's problems they have been unable to demonstrate this. Treatment services need to become more proactive in terms of engagement, outreach and harm minimisation.

There is a need for guidance for commissioners. Many do not have the knowledge of the range of issues and clients' needs in relation to alcohol. Commissioners are often unclear what they are commissioning in terms of alcohol services; hopefully an Alcohol strategy would offer some clear guidance in relation to commissioning targets

They often focus on activity and numbers in treatment rather than quality of outcome.

They do not recognise the need for a comprehensive range of services or that expansion of one part of a service will ultimately place demand on other parts e.g. Hospital Liaison→ treatment services.

Evidence is that for every £1 spent on Drug Treatment, £3 saved on crime. Elements of this must be transferable to Alcohol Treatment.

The expansion of drug treatment and accessibility has seen a massive increase in client's engagement in services, through various access points.

We believe that Alcohol Services can have a comparable activity and a range of services that is appropriately resourced.

There are a number of interventions that can minimise and prevent injuries presenting at A & E.

Safe initiatives e.g.

- plastic glasses etc,
- Transport home.
- Increased policing
- Staggered closing times
- Changes in drink / driving limits – zero limit
- Implementation of work place alcohol policies, especially with machinery
- Free smoke alarms

There are strong links between alcohol misuse and mental health, with alcohol initially being used and then misused because of its effect e.g. disinhibited, depressant, relax, oblivion, sedation, many people use it as medication to treat other problems. Obviously, because of the effects listed these can ultimately compound the problems e.g. increase depression, nervous system an add anxiety. Its disinhibiting effect can allow people to act on thoughts of. Self harm, suicide and violence and aggression

Alcohol misuse is associated with a range of mental health problems the most common being, anxiety, personality disorders,co-morbid affective disorders and schizophrenia.

Services are better co-ordinated if they can be provided as part of an integrated care package Bolton Salford and Trafford Substance misuse services have some good examples of joint working including General Hospital liaison, Mental Health liaison and an inpatient unit treating Dual Diagnosis and working within the Care Programme Approach.

It is not helpful or often possible to make a distinction between primary and secondary mental health/alcohol problems ie which are the primary problem and therefore a multi-disciplinary, multi-agency assessment and interventions is needed.

4 Crime, Disorder and Anti-Social Behaviour: The Effects on our surrounding and community (Question 23 – 25)

Manchester ‘City Safe’ Scheme has highlighted the links between alcohol and crime and provided evidence of successful initiatives. Locally a number of forces e.g. Oldham have collated data regarding crime hotspots. The gaps are that information is not routinely collected by services in relation to alcohol **not** even by the police or Domestic Violence.

Alcohol is linked to re-offending in relation to drink and disorderly domestic violence and drink driving. It appears to lead to areas of violence especially fighting and assaults.

Factors influencing crime and disorder and alcohol include

- Crowds
- Overcrowding
- High density of licensed premises
- Drink promotions
- football

Some of these factors can be influenced e.g.

- Increasing public transport at night / early hours
- Increased use of CCTV and increased policing.

Need local councils, planning departments, licensing authorities and police to take responsibility.

The success of drink driving policies, has been a consistent clear message, i.e.

- the enforcement
- the high profile campaigns,
- the marketing of the campaign
- the penalties
- Local media 'name and shame' columns.

5 The Implications for Vulnerable People

We see the children and young people identified as most vulnerable as the same groups identified in the Young Persons Substance Misuse plan
In addition it would be useful to widen the definition to include high-risk groups. Anecdotal evidence is that young people with a high disposable income i.e. "cheque book kids" can also be vulnerable.

Additionally there are risks associated with drinking and teenage pregnancies and sexually transmitted diseases due to the relationship of intoxication and unprotected sex.

Again it may be useful to refer to vulnerable and high-risk groups to encompass women, mentally ill and occupational groups such as doctors, police, licensees.

Vulnerable groups should also include Hard To Reach groups who don't access services for a number of reasonse.g.black and minority ethnic groups, women and mental ill. Access may be difficult due to the design of services and its philosophy e.g.only motivated clients, abstinence only. Other reasons include Lack o0f anti-discriminatory practice training, lack of awareness, poor diversity in the workforce etc.
Often services exclude some complex patient due to the way services are provided i.e. location, opening times appointment only, waiting times or because they are unable to demonstrate motivation or conform to the service specification.
Services need to respond to the needs of all its clients and be able to prioritise those most vulnerable or at risk eg younger drinkers,homeless,dual diagnosis, pregnant women,brain damaged drinkers
In terms of joint working we would utilise the principles of the Care Programme Approach carrying out multi- disciplinary reviews with care plans.
We also employ a number of specialist post which enables joint work for instance a mental health liaison nurse and A and E liason. Pressures on services and exclusion criteria can get in the way of joint work.

We have developed a range of strategies and service specifications in Bolton, Salford and Trafford to respond to this diverse client group but further work, resources and research is required.
We feel mainstream services struggle to deal with this often complex and difficult group because of the issues mentioned above but also attitudes and lack of skills and knowledge. Feedback from clients is of a poor service and negative attitudes

6 Education & Communication (questions41-50)

Advertising & marketing are powerful tools, which are rarely used in education regarding the use and misuse of alcohol.

Health promotion messages, raising awareness can be effective as in smoking, diet and drink driving. With the loss of national campaigns there is no forum to promote sensible drinking messages, except on an individual basis.

The messages are very confusing in relation to units and benchmarks and how these are calculated. Clearly when adults do not understand units in relation to alcohol then as parents they are unable and unequipped to educate their children.

TV is a very powerful tool for the promotion of alcohol and should also be used to inform people of the risks. Messages could be delivered consistently via packaging as with cigarettes.

Manufacturers of alcohol are profit making organisations and invest considerably in marketing and promotion of certain products. Many products appear to be targeted at young people. The Portman Group has dismissed many complaints regarding this. The Code of Practice in relation to advertising and the self-regulating nature are questionable in its objectivity and we require an independent regulating body.

7 The Shape of the Market and Market based Solutions (Questions 51 – 55)

Over the next 10 years it is likely that the alcohol industry will continue on its current path along with changes in relation to licensing laws – 24 hour drinking in towns and cities.
Health promotion messages should be included on alcohol packaging as with cigarettes e.g.intoxication can lead to unprotected sex.

As in city safe scheme working in partnership there have been some innovative market led solutions to dealing with the problems of alcohol misuse.

Sports sponsorship is a commercial interest, which can impact on drinking behaviour.

8 The Economic Costs and Benefits of Alcohol

Alcohol should not be promoted in terms of being beneficial, in the workplace in relation to relieving stress and facilitating relationships, particularly in the face of evidence in relation to the extent of problems related to accidents, absenteeism. There is evidence relating to drink driving to show even small amounts of alcohol affect driving ability. There are limited beneficial effects of alcohol consumption for a small and very specific group of people but this message as been misinterpreted and promoted especially in the media. Therefore it is essential we give the right information in the best possible way.

A comprehensive strategy, which deals with education, prevention, treatment and rehabilitation as well as addressing the issues, associated with individuals, families and communities will require significant resourcing. Tax revenues should be directed to fund this in a similar way that drug monies have been utilised.

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On behalf of Bolton Salford and Trafford Mental Health Partnership NHS