editorials

Psychiatric Bulletin (2001), **25**, 201–203

DUNCAN RAISTRICK

A national alcohol strategy for England

Addiction psychiatry is at an interesting stage of development and seems to be set on a path that will part company from general psychiatry. As the NHS enters a period of unprecedented growth linked to modernisation, then so specialisation will slowly become the norm. It follows that the future direction of alcohol policy is a matter of interest and concern to all psychiatrists and the forthcoming National Alcohol Policy represents a timely opportunity for reflection. There has been a remarkable absence of alcohol policy over recent years, indeed, so much so that the forthcoming strategy is expected to be the most important policy statement since the Kessell Report (Department of Health and Social Security & The Welsh Office, 1978), which laid down the blueprint for the current pattern and range of community-based alcohol services. Of course the strategy may turn out to be a fudge, a disappointment and an opportunity lost, however, there is encouragement from the *National Service Framework for Mental Health* (Department of Health, 1999*a*) that government thinking about addiction services is moving the right way because:

(a) brief interventions are to be more widely available
(b) services will be integrated to deal with people at risk of suicide
(c) strategies will be developed to deal with dual diagnosis patients
(d) integration of specialist and other services is to be seamless.

If these themes are developed in the National Alcohol Policy then it is clear that there will be a broadening of the base of addiction services, perhaps to include addiction medicine and public health, while at the same time preparing for specialty status of the field. In many parts of the country addiction services are already integrated with primary care teams through the requirement on health authorities to establish shared-care working for opiate users (Gerada & Tighe, 1999). The success of shared-care needs to be extended within the NHS family. Addiction problems present in most areas of health and social care and it is inevitable that broadening the base of services means not only integrating a greater variety of professions, but also working in a wider variety of settings.

In 1996 the Society for the Study of Addiction launched a project that had the objective of pulling together the evidence to inform a National Alcohol Policy. The principle output from this project was a book called *Tackling Alcohol Together* (Raistrick *et al*, 1999). The project was nicely complemented by an Alcohol Concern agenda to consult widely in and around interested parties and seek a consensus on policy direction. The writing of *Tackling Alcohol Together* involved a slightly unusual process. A number of distinguished practitioners and scientists from the addiction field agreed to prepare position papers on their personal subject areas. These papers were debated by the project group and the final agreed versions of text were then merged to make up suitable chapters. This proved to be an effective, albeit exacting, way of working. Thus the book is a composite of text, views and debate from the experts involved.

What must be seen as curious is the enthusiasm with which the National Drug Policy has been embraced as compared to the resistance that meets any discussion of alcohol policy. If a drugs policy is such a good thing then why not an alcohol policy? One answer to this question is that we have personal and cultural ambivalences about any restrictions on our drinking behaviour. Day-to-day leisure activities frequently include drinking. For example, one survey found that in the previous 3 months 74% of adults had visited a public house and 69% had had a meal in a restaurant; of activities not usually associated with drinking, 34% of adults had been to the cinema, 22% to a museum or art gallery and 17% to the theatre (Office for National Statistics, 1999). The General Household Survey of 1998 found that 75% of men and 59% of women had taken a drink in the previous week; 27% of men and 15% of women were drinking in excess of the safe limits of 21 and 14 units, repectively (Office for National Statistics, 2000). In short, drinking is something that most people in the UK like to do, however, there is also an understanding about the meaning of social drinking and when drinking is inappropriate. For example, in a survey of support among the general population for alcohol policy options, Pendleton *et al* (1990) found that 92% wanted to enforce the law on under-age drinking, 91% wanted to enforce drink–driving laws, 88% wanted labeling of the alcohol content of drinks, 80% wanted a ban on alcohol at sporting events, 47% wanted to reduce off-licence opening hours and 46% wanted to reduce the total of

https://doi.org/10.1192/pb.25.6.201 Published online by Cambridge University Press

editorials

drinking outlets. It looks as though the public are more willing to endorse policy options that will affect other people than they are to endorse options having a personal impact.

At a cultural and political level there is also ambivalence. The UK has a world class drinks industry that employs in excess of 1 million people through production of alcohol onto sales in hotels, restaurants, pubs and clubs (Brewers and Licensed Retailers Association, 1999). The UK is estimated to be the fourth largest producer of spirits and the sixth largest producer of beer in the world (Productschap voor Gedistilleerde Dranken; 1999). An industry of this size generates huge tax revenue for the government, estimated in 1998 at £10 033 million, 3.3% of total tax revenue. This tax was derived from £29.7 billion of consumer spending on alcohol in 1998 or, put another way, £56 507 spent every minute of every day. So, while the rhetoric of a drugs war is guaranteed to fire up political and public support, a war on alcohol would be political suicide. Certainly there are strong economic and probably personal enjoyment reasons for keeping a relaxed view of alcohol policy, but there is also a conspicuous down side to drinking.

The relationship between patterns of drinking and alcohol-related harm is complex. In broad-brush terms intoxication is most commonly associated with social harms, accidents and violence, whereas regular drinking is most commonly associated with health problems. There is plenty of choice when picking examples of alcohol-related harms. For example, the National Association for the Children of Alcoholics (2000) report 920 000 children living in a home where one or both parents misuse alcohol, and 6.2% of adults having come from a drinking family. The Health Education Authority (1997) estimated 60% of para-suicides, 30% of divorces, 40% of domestic violence and 20% of child abuse to be associated with alcohol misuse. A report from the Social Exclusion Unit (1999) found that, after drinking, 20% of young people report having sex that they regretted, 10% could not remember whether they had had sex and 40% were likely to have casual sex. The impact of alcohol on the Health Service is huge, albeit that the data are frequently incomplete. For example, the Department of Health (1999*b*) report between 5000 and 45 000 deaths per annum attributable in whole or in part to alcohol misuse; the lower figure is calculated on illness directly related to alcohol, such as liver cirrhosis, whereas the higher figure includes illnesses where alcohol is one of several factors, such as hypertension or stroke. In 1995/1996 there were 72 500 hospital admissions with a mention of mental and behavioural disorders owing to alcohol and nearly half of these had alcohol dependence as the primary diagnosis.

The *Tackling Alcohol Together* project set out four key policy objectives that are reproduced in this article (see Box 1). A National Alcohol Policy has the difficult job of balancing the conflicting interests of stakeholders. For example, there is a need to balance individual freedom to drink alcohol against the impact that this might have on others; there is a need to balance the benefits of a successful drinks industry against the damage to the public health of unfettered drinks promotion. Alcohol policy is a kind of social system where the component parts are in a dynamic relationship so that a change in one part of the system ripples throughout the whole. For this reason *Tackling Alcohol Together* calls for strong national coordination of policy. The Home Office (2000) proposals for reform of licensing laws are an example of why coordination is so important: in essence, the reforms are aimed at reducing public disorder by extending drinking times and clamping down on unruly pubs and clubs. The difficulty is that the reforms may well work for the Home Office by reducing problems of intoxication, but may not be what works for the Department of Health because increased availability of alcohol would lead to an increase in regular drinking and health problems (Drummond, 2000). Serious policy must be coordinated across government departments. The role of the National Treatment Agency, which came into being in April 2001, has yet to be clarified – it is crucial that the Agency take on alcohol as well as illicit drugs.

Psychiatric services will have difficulty benefiting from the opportunities of a National Alcohol Policy unless mental health trusts lay down plans to prioritise addiction services. Appointing suitable consultant staff will be thwarted because there is a dire shortage of trained addiction psychiatrists and a shortage of suitable training placements for specialist registrars wishing to specialise in addiction. It seems likely that medical directors are going to need to do some imaginative thinking on how to bridge the manpower and service gap. One idea is for health authorities within a region to join together, as a transitional measure, and appoint a peripatetic team

Box 1 The *Tackling Alcohol Together* project four key policy objectives

(1) Increase public information and debate about alcohol

- create a national coordination structure
- ensure the availability of statistical information
- promulgate a simple 'safe limits' message
- develop media advocacy locally

(2) Encourage the drinks and leisure industries to introduce schemes to discourage drunkenness

- drug action teams to be responsible for community action on alcohol
- evidence-based reform of licensing regulations
- server training programmes
- incident monitoring to inform local action

(3) Maximise community and domestic safety

- no tolerance of domestic violence
- reduce drink–driving prescribed limit to 50 mg %
- increase age limit for targeted drinking activities
- support work place policies

(4) Reduce alcohol-related health problems below 1990 indicator levels

- measures to maintain per capita consumption <8 litres
- accredited addiction training courses
- improve effectiveness of treatment
- improve access to specialist treatment services

https://doi.org/10.1192/pb.25.6.201 Published online by Cambridge University Press

editorials

linked to an established centre. This could be attractive both to specialists thinking of retirement and specialist registrars looking for a full-time position with prospects. There will be plenty more 'sticky plaster' solutions to come. What is important is the debriefing after the publication of the National Alcohol Policy: what will psychiatry then do to advance the need for a modern addiction specialty?

References

BREWERS AND LICENSED RETAILERS ASSOCIATION (1999) *Statistical Handbook*. London: Brewing Publications Ltd.

DEPARTMENT OF HEALTH (1999*a*) *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Stationery Office.

— (1999*b*) *Statistical Bulletin. Statistics on Alcohol: 1976 Onwards*. London: Government Statistical Service.

DEPARTMENT OF HEALTH & SOCIAL SECURITY & THE WELSH OFFICE (1978) *The Pattern and Range of Service for Problem Drinkers: Report on the Advisory Committee on Alcoholism*. London: HMSO.

DRUMMOND, C. (2000) UK Government announces first major relaxation in the alcohol licensing laws for a nearly a century: drinking in the UK goes 24–7. *Addiction*, **95**, 997–998.

GERADA, C. & TIGHE, J. (1999) A review of shared care protocols for the treatment of problem drug users in England, Scotland and Wales. *British Journal of General Practice*, **49**, 125–126.

HEALTH EDUCATION AUTHORITY (1997) *Health Update – Alcohol*. London: Health Education Authority.

HOME OFFICE (2000) *Time for Reform: Proposals for the Modernisation of Our Licensing Laws*. London: Stationery Office.

NATIONAL ASSOCIATION FOR THE CHILDREN OF ALCOHOLICS (2000) *Preliminary Survey Findings*. Bristol: NACOA.

OFFICE FOR NATIONAL STATISTICS (1999) *Social Trends 29*. London: Stationery Office.

— (2000) *Living in Britain: Results from the 1998 General Household Survey*. London: Stationery Office.

PENDLETON, L. L., SMITH, C. & ROBERTS, J. L. (1990) Public opinion on alcohol policies. *British Journal of Addiction*, **85**, 125–130.

PRODUCTSCHAP VOOR GEDISTILLEERDE DRANKEN (1999) *World Drink Trends*. Henley-on-Thames: NTC.

RAISTRICK, D., HODGSON, R., & RITSON, B. (eds) (1999) *Tackling Alcohol Together*. London: Free Association Books.

SOCIAL EXCLUSION UNIT (1999) *Teenage Pregnancy*. London: Stationery Office.

Duncan Raistrick Clinical Director, Leeds Addiction Unit, 19 Springfield Mount, Leeds LS2 9NG

Psychiatric Bulletin (2001), **25**, 203–205

EDWARD PETCH

Risk management in UK mental health services: an overvalued idea?†

Criticism has been directed towards mental health services during the past decade for failures in managing risk effectively, but this has not resulted in significant improvements in training, which many hospital trusts still do not seem to provide (Davies *et al*, 2001, this issue). Morris *et al* (1999) called for a national programme of training for professionals, which could improve skills. This may be especially valuable for the half of professionals whose skills are below average.

Misperceptions about risk

The government has made a significant contribution to public misperceptions about mental illness and risk by emphasising risk in many of its announcements (Health Select Committee, 2000) and continuing to promote inquiries into homicides despite the fact they make little sense (Szmukler, 2000). Over recent years the primary concern appears to have been to manage risk: the objective to provide better health outcomes for patients is put into second place (Holloway, 1996). This is a regrettable shift in the political agenda, which appears increasingly to be ruled by the desire to avoid adverse headlines and to shift responsibility. The result has been a change in the climate of psychiatric services, which inevitably become risk orientated. This has led to a number of adverse consequences for our patients and the profession: increased stigma, problems with recruitment and retention, attribution of blame and low morale (Health Select Committee, 2000; Szmukler, 2000).

It is possible, through the delivery of a high standard of care, to avert the deterioration in people with mental illness, which can lead to disaster. However, not all acts of violence can be predicted, just like they can't be predicted in the wider community. It is too easy for public condemnation to focus on overstretched mental health services when something goes wrong. There has been a shift in community care from care by networks of family and friends to that of professionals, and with this has come the expectation that professionals will always get it right. There are and always will be people in the community who are a risk to others, whether or not they suffer from a mental disorder, and singling out different professional groups for blame, whether they be social workers, psychiatrists or doctors in general, won't change this.

Problems with risk assessment

The perception that risk assessment and management will reduce the rate of adverse incidents is flawed. Munro and Rumgay (2000) analysed the findings of public inquiries held after homicides by mentally disordered offenders in the UK and concluded that improved risk assessment has only a limited role in reducing homicides by people suffering from mental illness. This is because only a small proportion of those who are violent give any

†See pp. 217–219 this issue.

https://doi.org/10.1192/pb.25.6.201 Published online by Cambridge University Press