With regards to the merging of substance misuse services, are there differences in the way that people with alcohol-specific problems tend to seek or respond to professional help?

One of the problems you’ve got with substances as a whole is the treatment budget is limited. There will always be more demand than you can meet. You could end up cutting your addiction services multiple different ways, so you could have a heroin-only service, then you could have a poly-drug and alcohol-using service, a Novel Psychoactive Substances (NPS) service, etc and you could have an alcohol-only service. Dividing services in so many different ways would make many unsustainable with restricted opening hours. I don’t think the money is there in the system to have special alcohol services, but we need to recognise the alcohol-dependent patients as having different and equal needs.

What is clear is that the approach needs to be nuanced. You cannot approach the treatment of alcohol dependence with a heroin hat. Just like you can’t approach NPS with a heroin hat. You can’t take a single model to fit all substance treatments. Nor can you allow opioid targets to dominate the service to the exclusion of alcohol-dependent people, because in every local area, when it comes to population-wide use, your number one problem substance is alcohol. Therefore, you need to be able to develop services which can give alcohol equal status and recognise that you need a pathway that can address alcohol.

How does that pathway begin?

In Lambeth the vast bulk of people self-present to services. If we’re able to provide opioid-dependent patients with same-day scripts of methadone who turn up, why can’t we provide the alcohol-dependent with same-day assessments and initial treatment of alcohol in the same way? We should catch people at their point of motivation, when people have motivation to come to a treatment service, because motivation fluctuates.

I am not a great fan of endless assessments before an alcohol-dependent patient receives some intervention. I’m not a great believer in this idea of delaying patients for long periods until they are assessed as being ready for detox. It is difficult to know what ‘ready’ means. It can be hard if you’re drinking 10 pints a day to show appropriate engagement. So what we’re trying to do is move to a point where you detox people as quickly as you possibly can, if that’s what they request and they’re motivated.

We should endeavour to support ongoing recovery and address underlying, social, psychological and physical health issues.

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So it’s not a problem of being able to cater for the needs of alcohol-dependent patients within a substance misuse service, perhaps it’s about getting people to services when they’re ready and feel able to do so.

I think you can even move beyond that. What’s nice is to have a multiplicity of entry points into your treatment system. So people can self-present here but also as we work with almost every GP practice in Lambeth, at their GP surgery. So if they don’t want to come to Brixton they can also see the addiction worker in the GP surgery. Furthermore by linking into hospital
alcohol care teams, if they detox someone in hospital, they can transfer their care to our recovery space.

I think you need to offer this range of options, because stigma runs many ways. There are alcohol clients who don't want to come to a drugs service and drug clients who don't want to be characterised as alcoholics. It is not that one setting is better than another; it is that individuals prefer different settings to meet their unique needs.

You've worked a lot with policy roles and commissioners. Sidestepping the obvious issues of budgets, are there any other key issues that you think alcohol treatment providers should be thinking about?

I'm not sure it's right to sidestep the issue of cuts. We can't get away from the fact that addiction services across England have taken significant cuts. This isn't the fault of local authorities; this is a reduction in
funding from the centre which slips through because addictions and indeed community sexual health are no longer part of the NHS. I am not sure this point is understood. I think if you look at the drop in numbers in alcohol treatment, my personal view is that you can’t separate it from cuts to services. I also think there is a definite problem that we’ve been cut off from the commissioning and planning of the NHS in its broader sense. For example, that we’ve been cut off in a way from the commissioning of liver services, primary care, pharmacies and mental health. At some point this needs to be addressed.

It is good that so many different options for treatment entry are available but there are also people who don’t make it to any of these entry points. Complexity dwells in many domains. It is not just those who repeatedly present to acute hospitals. For example, if you’re drinking yourself to death in a tower block somewhere and you’re not going to hospital because you don’t want to waste A&E’s time. Or, you’re someone who binge drinks to blacking out, but you’ve got two children in your care. These are different kinds of complexity. So we need to recognise the breadth of complexity when it comes to alcohol, and it would be lovely to have the resources to work more extensively with these groups who do not make it to services anywhere.

And detox is a big part of that.

Yes. We have a real crisis in England with the provision of inpatient detox. Funding reductions have meant that there are no longer 24-hour medically staffed detoxification units in many parts of the country; indeed there are none within the M25. This is worrying because we know alcohol is the leading cause of death in adults under 50 mainly associated with its physical and psychiatric co-morbidities. We are lucky in Lambeth that St Thomas’ Hospital and our local CCG have agreed for us to detoxify our most physically complex patients in their Medical Assessment Unit.

I think we need to acknowledge that many people drink alcohol because they’re anxious or depressed. Alcohol is both a marvellous elevator in mood and a suppressor of anxiety but only in the short term; as we all know, over time it makes these problems worse. Unfortunately some IAPT services exclude patients that use or have used alcohol until they are many months abstinent. This is contrary to positive practice guidelines that the NTA brought out in 2013. There needs to be an effort to make sure all IAPT services and addiction services are linked. So if people get detoxed they shouldn’t have to wait an arbitrary length of time to be sober before they can have psychological therapy. They should be able to flow into an anxiety or depression programme straight away once a detox is completed. I really think that is one of the crucial links we need to get much better at.

Taking a bit of a step back and thinking more broadly about alcohol misuse across society and people who don’t engage with treatment services, what would you like to see done in that particular area?

Lambeth, a borough of 300,000 people, has something like 1,700 places where you can buy alcohol. It’s available 24 hours a day. You can get the pizza company to deliver alcohol to your door. It’s too available, it’s too easy. We know there is a link between availability and levels of use. There’s a licensing issue which needs to be addressed. There is also a strong evidence base about Minimum Unit Pricing (MUP).

Alcohol is too cheap. This is not to be puritanical, but societies need to find the correct balance between availability of alcohol and the harms caused by such availability. In England my view is that we have made it too easy and cheap to buy.

There’s an important issue of autonomy isn’t there, that probably applies across the spectrum of alcohol misuse, whether someone is thinking about changing because they want to reduce feeling sluggish in the morning, versus someone who has these complex needs.

Over my time working in addiction with alcohol-dependent patients I’ve come to the conclusion that I’ve two overarching tasks. Firstly, trying to keep people alive by harm-minimising around their alcohol use. So for example, if they are suicidal they need an urgent psychiatric intervention. If they have cirrhosis treat their liver disease. If they are not eating provide vitamin supplementation to stop them getting Wernicke’s and Korsakoff’s. If they smoke, and more than half do, address nicotine dependence.

Secondly, supporting them to understand their autonomy and their internal capacity for change. I’ve never seen anyone change who doesn’t understand their own agency. An excessively biological disease model of addiction can get in the way if the alcohol-dependent individual views their problems as a disease which can be cured by a pill or a therapy rather than one they can help address. I think what I find troubling about an excessively biological model of addiction is that we risk reducing people’s resilience and ability to understand their own ability to change. We then fail to recognise the wider social setting where they exist. Of course our support and treatment needs to be available and offered. Of course we should recognise the biological drivers of alcohol dependence. But it needs to be as a partnership where both the patient and professional collaborate and we encourage patients to understand their agency.

When alcohol-dependent patients make that change it’s rarely an epiphany; rather a more gradual process, but it is amazing when you watch people making that transformation. Indeed many of the people I work with are in recovery from alcohol dependence. To steal a phrase from another field, they often appear ‘better than well’. They understand something about their ability to control their drives, their desires and how their drives and desires have damaged them.