WORKING LIVES

An NHS alcohol service

Clare Kambamettu, Elinor Llewellyn, Mary Longley and **Paul Davis** report on how they tackle problem drinking

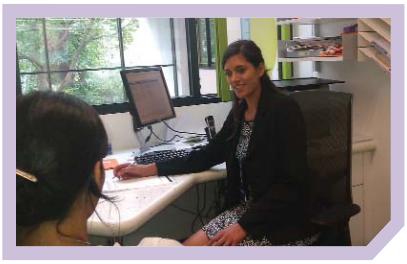
When I read about the evils of drinking, I gave up reading.
Henry Youngman

Alcohol services have become a hot topic within the NHS, partly because of the astronomical amount of money the government is forced to spend to deal with issues arising from alcohol misuse. A recent estimate put this at a total of £55 billion a year, almost enough to fill the current national deficit.

Our service was initially established to sit at the forefront of primary care, providing evidence-based interventions to motivate and support clients experiencing difficulties with their alcohol consumption. The individuals we see vary from 'hazardous' drinkers (above 21 units per week for men and 14 units per week for women) to those drinking at 'harmful' levels that are likely to have already caused some alcohol-related harm (usually above 50 and 35 units per week for men and women respectively). The former group run greater risks, for example, of accidents and injuries, unprotected sex and of developing health conditions. Harmful patterns of drinking can cause or exacerbate health problems like diabetes, liver disease, high blood pressure, various cancers, mental health problems and of course progression to dependent drinking. Drinking can also cause a host of social and family problems, and believe it or not even make you less funny (see 'No laughing matter').

One of our greatest challenges is to engage a population that is not typically help-seeking. Alcohol is widely acceptable within our society; it is seen as an appropriate way to relax, meet people and enjoy oneself. Because of the way it is perceived, the only people who tend to actively seek help in relation to their drinking are those for whom it had already caused a problem whether this is physical, social or psychological. Because hazardous patterns of drinking, including bingeing, are often seen as 'normal', people within this category tend to be most resistant to help.

Our service has been hugely successful in penetrating the GP practices within the borough and this has proved invaluable in terms of accessing the local population.



Clare Kambamettu *(pictured above),* **Elinor Llewellyn**, **Mary Longley** *and* **Paul Davis** *are based within substance misuse psychology services in Camden, north London*
clarekambamettu@gmail.com

The majority of our referrals come directly from GPs, so it is important to keep the pathways of communication open between our service and theirs. We try to attend clinical meetings as often as possible to make sure any issues are addressed and encourage them to contact us with any questions they might have. Other referral sources include psychologists, primary care mental health workers, health trainers and third-sector services.

Identification of appropriate clients is made easier through the use of screening tools. The tool we currently use is a 10-item test called the Alcohol Use Disorders Identification Test (AUDIT: Babor et al., 2001). Practice staff are encouraged to screen anyone who falls into targeted groups or anyone they feel may benefit from it. Following completion of the AUDIT, the staff member delivers a simple brief intervention lasting about five minutes, providing the client with some information and feedback about their alcohol use and offering a referral to our service if appropriate. We run frequent training events for those who wish to brush up on their brief intervention skills and this has proved very popular with over 250 people trained within our borough in a year. One of the things other professionals often say is that they don't feel fully comfortable asking their clients about alcohol, which often hinders the screening process. During training we try to address this issue as best we can in order to enable the most effective screening possible.

If a client accepts a referral to our service, we contact them to arrange an initial assessment, which usually last about 45 minutes. The first time we see a new patient we assess them individually to ensure we understand the level of support and treatment they will need and also to help us identify any other issues that may affect their treatment plan. Alcohol and issues such as social, family, housing or mental health problems are often inextricably linked, and many of our clients feel that they are unable to overcome their alcohol misuse

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until these other issues have been resolved. Of primary importance are the links between our service and other statutory and voluntary services. Often we are the first to identify such problems and as a result, a referral we could make to another service may make all the difference to the care plan that we initiate.

We predominantly use CBT and motivational interviewing (Miller & Rollnick, 2002; Rollnick & Miller, 1995) approaches within our work, employing a variety of strategies to encourage and maintain change in our clients. Behavioural experiments and thought/drink diaries prove extremely popular and are often the components that people report as effective in shaping thought processes around their drinking. In addition we use motivational interviewing to promote change; this style and these techniques have been repeatedly shown to be highly effective when helping clients who misuse substances. It must be stressed, however, that our model of working is collaborative and as such focuses on the client's own goals rather than those of the therapist. If the goals are inappropriate (e.g. a client with extensive liver damage thinks it is okay to continue drinking very heavily), we use advice and information-exchange given in a motivational style. A finger-wagging type of persuasion is unlikely to help. If the client is reluctant to change their goal, then this must be accepted by the therapist, who needs to be willing to continue working with the client to achieve their aim even if they disagree with it. For example, a 50-year-old man who has been drinking heavily for 30 years, who could well be physically dependent but does not wish to detox, or to be abstinent, but is concerned enough to want to do something, must be granted the opportunity to achieve his own goal even if it goes against most people's idea of what would be best.

Many of our clients come to us confused by conflicting messages in the media. We can all recall at least one client who, after calculating their excessive alcohol intake, cried 'I heard that wine was good for my heart!' Although there is some evidence that a very small amount of alcohol (approximately one unit) can bring positive benefits to post-menopausal women and men over 40 (British Heart Foundation, 2007), drinking beyond sensible limits still seems to bring more harm than good. Perhaps if someone is drinking for the sake of their health, it's better to exercise or eat more healthily: not what people want to hear or believe, but the truth nonetheless! Even more challenging is the patient who chooses to withhold their true alcohol consumption. 'Oh, just a couple of glasses of wine' they might say, failing to mention that they are drinking from pint glasses!

Alongside negotiating the challenging behaviour of some clients, working in an alcohol team can be a very rewarding experience. The sheer variety of patients in primary care is staggering: young professionals indulging in too many boozy client lunches; stay-at-home mums drinking to relieve boredom and stress; students starting to feel the toll of cheap vodka nights out; builders who go to the pub 'with the lads' after work. Aside from seeing patients, one of the main roles we play is promoting alcohol awareness, and removing the stigma from discussing one's alcohol consumption. People often boast about being able to 'drink someone under the table' or accusing someone of being a 'lightweight', but when it comes to raising concerns about their own drinking levels, people can be surprisingly inhibited.

Time and time again, the research has shown that other than price controls, a good way to help people approach behavioural change is to give them information that is meaningful to their personal circumstances. The government aims to do this around alcohol through a number of different campaigns, most popularly 'Know your limits' and 'Know your units'. An important part of our role is to work closely with the health promotion alcohol team and attend community events promoting these messages. This allows us to be on hand to reach out to the community we try to serve. By attending community events, we aim to raise the profile of sensible drinking recommendations and remind people that it's okay to speak to their GP or an alcohol service if they have any concerns about cutting down. Many people fear being branded an 'alcoholic' so we aim to dispel myths around alcohol services, and instead encourage individuals to approach their drinking as they might approach their diet: it's okay to drink, but in moderation.

No laughing matter

Most people believe that drinking alcohol in moderation can make you feel funnier, more sociable and a better person to be around. Pavis et al. (1997) found that the belief that alcohol aids social interaction was the single most important reason for drinking among Scottish 15-year-olds. Research among students (Johnson, 2006) found that they believed that drinking enhances the quality of interaction when meeting people. They made statements such as 'friends seem and act funnier' when drinking and 'alcohol is a fun drug, it makes reality better'. But few drinkers we see as psychologists in an NHS alcohol clinic appreciate that regular drinking not only puts them at risk of numerous health problems; it also seems likely to have a significant negative impact upon the sense of humour that they value so highly.

Shammi and Stuss (1999) have hypothesised a direct link between damage to the right frontal lobe in head-injured patients and their ability to appreciate humour. Using a number of 'humour tests' involving punchlines, humorous statements and non-verbal cartoons, the researchers were able to conclude that damage to the right frontal lobe does seem to impact upon the individual's sense of humour, similar to the personality changes that occurred in the famous case of Phineas Gage.

In the field of alcohol misuse, frontal lobe damage and executive functions including social cognition, but not sense of humour, has been relatively well researched over the years (Moselhy et al., 2001). Uekermann and Daum (2008) report in their review of alcohol and executive functions only two studies showing that people with alcohol dependence were impaired in processing humour. The participants in these studies commonly chose endings to cartoons that were unrelated to the main topic of the cartoon and often failed to select an appropriate punchline to jokes. Whether these deficits are specifically related to humour or to other aspects of cognitive functioning and affective components is, however, unclear. We are missing the studies that can tease out humour appreciation in drinkers (and not just at the dependent end of abuse). This is vital because brain changes and cognitive problems are of importance to rehabilitation, and may help predict rehabilitation outcomes.

Many of the patients we see find the Department of Health recommended sensible drinking limits (14 units per week for women, 21 for men) laughable, often reporting they can drink this amount in one day). Perhaps with the potential conclusion that alcohol can have an impact upon your sense of humour, heavy drinkers would start taking the risks more seriously.