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SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS
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Alcohol Detoxification in Specialist Settings and Mental Health Treatment

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SHAAP/SARN 'Alcohol Occasional' Seminar Thursday, 18th December 2014, The Royal College of Physicians of Edinburgh

Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) are proud to support the lunchtime 'Alcohol Occasional' seminars which showcase new and innovative research on alcohol use. All of the seminars are run in conjunction with the Royal College of Physicians of Edinburgh. These events provide the chance for researchers, practitioners and policy makers and members of the public to hear about new alcohol related topics and discuss and debate implications for policy and practice. The current theme for the seminars is "Alcohol and Young People". Briefing papers, including this one, aim to capture the main themes and to communicate these to a wider audience. SHAAP is fully responsible for the contents, which are our interpretation.

Commenting on the theme of the new season of Occasionals, Smith said that he was very keen to see how the subsequent speakers, all of whom coming from different backgrounds, would explore the association between alcohol misuse and mental health.

As a psychiatrist specialised in the field of addiction, whose research interests include the history both of psychiatry and of alcohol treatment, Smith discussed historical reasons for why psychiatry has been concerned with alcohol misuse treatment. He gave different examples such as claims linking gin drinking with melancholia and dementia, and cited historic medical journals' articles on "alcohol insanity".

Coming up to the present, Smith drew attention to the fact that conditions such as hallucinosis and alcoholic hallucinosis receive similar medical treatment, and that this is also the case with alcohol depression and depression. He pointed out the overlap between alcohol misuse and mental health, so that alcoholism might itself be treated as a mental disorder. He also asserted that, despite hyped-up claims through the media that alcoholism might be genetic, or that alcohol and other drugs cause mental illness, such cause and effect links have not yet been established by aetiology, the medical field that considers the causes of diseases. Smith showed that such ideas can be traced back to the 19thCentury, when it was already thought that alcohol could be a cause of mental health conditions, such as insanity.

Smith also talked about how alcohol misuse is nowadays often associated with a wide range of psychological and physiological complaints, and his presentation listed conditions such as insomnia, depression, anxiety, self harm, amnesia, cancer and heart disease. He explained that alcohol misuse has been associated with attempted suicide and suicide, and that alcohol has also been connected with other issues, including homelessness, sexually transmitted infections, unwanted pregnancies, offending behaviours, domestic violence and child neglect.

Smith argued that, although it is said that people drink because they are depressed or, conversely, that they are depressed because of their drinking, different conditions might co-exist with alcohol. It might be the case that a condition only becomes evident when alcohol is ingested, since chronic heavy drinking has been associated with many harmful effects, such as the impairment of functions of the central nervous system. It might also be the case that a person is not only drinking heavily, but has other unhealthy behaviours as well, such as smoking or not eating well.

Moving to the specific Scottish clinical context where he works, Smith explained that, following best practice guidance detailed in Models of Care for Alcohol Misusers (MoCAM), a DH publication, NHS treatment for alcohol problems is delivered through four tiers. Delivery of services varies from those provided by generic community-based organisations to high intensity medical settings, such as the day-and- residential detoxification clinic where he practises. As clinical settings

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handle the toughest cases, what he and other NHS practitioners see might be the tip of the iceberg of what is happening within the communities from where patients are coming.

Smith's slides illustrated how contemporary alcohol detoxification clinics, such as the one where he works, fit within broader historical contexts. He gave examples of different places where people used to be sent to try to withdraw from drinking alcohol. Historical researchers had documented over centuries that, undergoing the withdrawal process, patients presented physiological and psychological complaints, which were sometimes new and often extreme.

Smith explained that many researchers now consider the withdrawal process as significant as addiction itself, and that they are investigating what takes place during the process of withdrawal from alcohol (as well as other drugs). In the past, researchers had sought agreement with subjects in order to induce addiction to substances from which they would then be managed to withdraw. Smith indicated that, nowadays, this would be considered ethically unacceptable.

Smith then discussed the withdrawal process. For any drug, this is often characterised by symptoms and signs which are opposite to those manifested following the intoxication. Therefore, while some patients report that drinking helps them to deal with their anxieties, they might become anxious during the withdrawal process. He also explained that the mood of patients with underlying alcohol problems undergoing detoxification can improve with withdrawal from alcohol.

Smith then went on to discuss the use of new technology in the form of breathalysers in treatment contexts. There is obviously some overlap here with other contexts, such as the policing of drivers. In both contexts, however, those being breathalysed – drivers and patients – have found various methods to try to avoid detection. The most bizarre he had come across was a man who had tried to eat his underpants, probably thinking that the cloth would soak up some alcohol from his system. The audience was interested in the types of breathalysers and how they were used. The serious question was raised in discussion, however, of where such scientific tests interacted and potentially interfered with the trust relationship that needs to exist between medical practitioners and patients.

Smith commented that practitioners have been using other tests, such as analysis of samples of blood, hair or urine, and that there are also bracelets available. He also highlighted that that there is evidence indicating that it is helpful for treatment when patients know that they are being monitored. However, scientific tests are not full-proof. Sometimes patients test positive, but they say that they have not been drinking and, conversely, there are cases when the test comes out negative, but the practitioner has an intuition that the patient has been drinking. This is often confirmed afterwards in conversation with the patient.

While testers are sometimes used to detect if patients have been drinking, Smith explained, the technology cannot indicate how much alcohol people are consuming over time or what their drinking patterns are. As well as this, people who are highly tolerant of alcohol may metabolise the substance very quickly. He also argued that the reasons why patients continue to drink while undergoing detoxification deserve analysis too, so that effective support responses can be put in place. Evidence indicates that patients not drinking while in detoxification do better.

Smith rounded up with some comments and recommendations for policy makers. First, he pointed to the clear evidence that in-patients benefit significantly better than day-patients from alcohol treatment services. He also argued for the importance of evidence-based, 'whole population' approaches as part of a comprehensive alcohol strategy. This includes elements such as prioritising public health concerns in granting alcohol licences and action to raise the price of the cheapest, most harmful alcoholic beverages through implementing Minimum Unit Price legislation.

Forthcoming Occasionals

Our next events in the current series of Alcohol Occasionals will be:

Staying Strong: Resilience, Alcohol and Destitution following the Asylum Process in the UK

Dr Fiona Cuthill, University of Edinburgh

12:30–14:00, 26th February 2015

Recovery, Mental Health, Alcohol and Nursing

Dr Anne Whittaker, NHS Lothian and Edinburgh Napier University

12:30–14:00, 23rd April 2015

Alcohol-Related Brain Disorders

Dr. Aisha Holloway, University of Edinburgh

12:30–14:00, 18th June 2015

These events are popular and places are limited. We need you to confirm if you would like to attend. You can do this by registering via EventBrite through our website at **www.shaap.org.uk/events.html**

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