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From the editor



Dr Dominique Florin

MCA Annual General Meeting and seminar on Alcohol and the Military

In November the MCA's highly successful AGM took place at BMA House. The Max Glatt Memorial lecture was given by Professor Tom Babor, on 'Problem drinking in the UK: public health implications of defining a drinking epidemic as a "corporate-borne disease"'. Professor Babor is an accomplished speaker and gave a very thought-provoking presentation, which invited us to consider the alcohol problem in broad public health terms and to consider solutions beyond individual clinical or educational interventions. The model he presented suggests that our focus should move beyond the 'agent' (alcohol) and the 'host' (the drinker) to the 'disease vector' – the alcohol industry. Following this lecture, Dr Bruce Ritson presented Professor Babor with the Max Glatt Memorial Medal. In a second talk that morning, Dr Marsha Morgan presented us with an 'insider's view' of the process leading up to the publication of the tripartite NICE guidance on alcohol, and associated documents. This was a challenging presentation which highlighted the boundary issues and frictions which arise when a large body of evidence is coalesced into policy advice, particularly in a changing policy environment which has implications for the ways in which the NICE recommendations may or may not be implemented.

In the afternoon, the seminar focused on issues around alcohol and the military. The session was

chaired by Dr David Marjot, who recounted his experiences as a psychiatrist in the navy. This was followed by Dr Walter Busuttill, medical director of Combat Stress, who spoke of the links between alcohol and post-traumatic stress disorder in retired combatants. Both Dr Marjot and Dr Busuttill have already written articles on these topics for previous issues of *Alcoholis*. Dr Nicola Fear then gave an epidemiological account of alcohol use in the UK military. This demonstrated that there are significantly higher levels of use than in the general population, and also in comparison with the US military. There was an interesting discourse as to the causes of these differences. Finally Dr Sharpley, a psychiatrist currently serving in the military, gave us an account of the level of the problem and the way in which it is dealt with. Dr Sharpley has written up his talk for this issue of *Alcoholis* (see page 4). The afternoon talks gave rise to some lively discussion, and for those of us not familiar with the military there was a sense of being given a privileged glimpse into a secret world.

The day as a whole was extremely successful. Over 100 delegates attended and, in addition to the excellent formal presentations, there was plenty of opportunity for informal networking in a most pleasant venue.

Changes at the MCA

The AGM marked the culmination of a series of changes at the MCA over recent months. Dr Ritson expressed great thanks on behalf of the MCA to Professor Peter Brunt, who has demitted office as chairman after a total of six years of service, from which the MCA has benefitted enormously. Very fortunately, Professor Brunt has agreed to stay on as vice-president alongside Dr Ritson, so the MCA will continue to gain from his experience and energy. Also very fortunately, Professor Colin Drummond has agreed to take on the chairmanship of the MCA, and this was confirmed formally at the AGM. Professor Drummond is well known at the MCA, having served many years on the Education Committee, ►

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From the editor *continued...*

and of course is extremely well established in the alcohol field. In an article in this issue Professor Drummond describes how he came to work in this area and outlines his thoughts about the future of the MCA (see below). Another important change is that Dr Alastair Beattie has resigned after many years' dedicated service as chair of the Education Committee. We are very grateful that Dr Beattie has agreed to remain active at the MCA as a member of the Executive. The new chair of the Education Committee is Dr Anne McCune, who is already a very active member of this committee, so this important area will surely continue to expand.

Student activities

Work with medical students remains one of our most important areas of activity. In this issue we announce two new competitions for 2012: the Michael Frowen Memorial Essay Prize and the National Alcohol Awareness Day poster design competition. Both of these are open to UK medical students, so if any of our readers fall into that category please do apply, or alternatively pass this onto those who do. A new venture in this area is our online student newsletter, *Alcoholomania*, which will shortly be available on our website and through our regional advisers. This will be another opportunity for medical students to read, and write, about alcohol related issues. We welcome contributions.

Professor Colin Drummond takes over the reins as Chairman of the MCA



I am delighted to be taking on the role of chairman at such an exciting time in the history of the MCA. After a long period of uncertainty about the future, there is now significant cause for optimism, thanks to the hard work my of predecessor Peter Brunt, medical director Dominique Florin, and members of the executive. I am most grateful to them for their help and kindness in easing me into this new role. As part of that process I thought it would be timely to tell you something about myself and where I would like to see the MCA heading.

I first developed an interest in alcohol problems when I was a medical student in Glasgow in the late 1970s, which is perhaps surprising given that I can recall only a one-hour lecture on alcohol misuse in five years of undergraduate training! Hopefully that has now improved thanks to the work of the MCA. Soon after I started working on the wards in Rab C Nesbitt's neck of the woods in Govan, it became apparent that much of the pathology was related either to alcohol or to tobacco use, combined with extreme social deprivation. I was also greatly influenced as a medical student by consultants (including – I hope he won't mind me reminding him – Alistair Beattie) who, rather before their

time, were champions of treating addictions as underlying causes of physical illness.

There were strong links between psychological medicine and other specialties at the Southern General Hospital, and soon after house jobs I joined the psychiatry training scheme there. Part of the rotation involved working in the regional alcohol treatment unit. It is fair to say I have never seen such severe cases of delirium tremens or Wernicke's encephalopathy anywhere I have worked since, either in England or North America. Part of the job was to provide emergency medical care for patients being transferred from the Western Isles by

air ambulance to Glasgow. Taking off in high wind from a beach airstrip on one of the isles with a patient in delirium tremens and only a rudimentary selection of medications was all part of the experience! This was, after all, an era when 'risk assessment' had yet to be invented. These experiences, together with inspiring senior colleagues including Patrick Mullin and John Taylor, meant for me that a career in addictions was inevitable.

In the early 1980s I was more interested in heroin addiction than alcohol. Griffith Edwards agreed to publish my first paper in the *British Journal of Addiction*, and soon after, quite out of the blue, he invited me to come and work with him at the Maudsley Hospital as a lecturer in the Addiction Research Unit at the Medical Research Council. He quickly managed to persuade me that alcohol dependence was much more interesting than drug misuse as a subject for research. That, barring occasional lapses, has been the focus of my work for the last 25 years. The Institute of Psychiatry is an exciting place to work, and Griffith was a source of great inspiration and encouragement. As well as his inquisitive and incisive approach to research, he encouraged one to consider the 'bigger picture', including the world of alcohol policy and the research and treatment of alcohol problems outside the confines of the specialist treatment centre, both of which have remained enduring interests.

After completing my MD I worked for a year at the Addiction Research Foundation in Toronto with Mark and Linda Sobell and Robin Room, and then moved to St George's Hospital in London to work with Hamid Ghodse. After seven years in pretty much full-time research, this was a crash course in NHS politics, setting up a new alcohol service from scratch in south-west London. Looking back, that was the

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most challenging period of my career, essentially doing two full-time jobs – as an NHS consultant and an academic – and never quite satisfying either employer. But it was an enjoyable time and I learned from Hamid all there is to know about how to make things happen in spite of the NHS!

For the last eight years, I took on a third job as director of the Specialist Clinical Addiction Network (SCAN) based at the National Treatment Agency for Substance Misuse. I have had the pleasure of working with excellent creative colleagues to develop new ways of supporting the 1,500 or so addiction psychiatrists working in the UK. I still find this number remarkable given the handful of addiction specialists we had when I came into the field. Much of that expansion is the legacy of the tireless work of those pioneers mentioned so far in this article. Similarly, from one professor in addiction psychiatry in 1987 (GE), we now have eight practising and two emeritus. SCAN is now developing new educational initiatives for addiction specialists across medical, clinical psychology and nursing disciplines.

In 2007 the Institute of Psychiatry 'made me an offer I couldn't refuse' and I returned full circle to the same office I occupied 15 years previously. Since then I have been given the privilege of indulging various long-standing research interests with funding from the Department of Health, the Medical Research Council and the European

Commission. The main thrust of this has been examining new and more effective ways of providing interventions for patients with alcohol problems presenting to the acute hospital and primary care, as well as working with NICE to develop national guidelines for alcohol treatment.

We are at a point in the history of the MCA when its importance has never been more relevant. There is no question that we are in the grip of an alcoholism epidemic in the UK. To a large extent we already now know what works in terms of alcohol policy and practice. But there is a huge gap between the evidence base and what happens in practice in the UK. The MCA, together with the medical royal colleges, the Alcohol Health Alliance, Scottish Health Action on Alcohol Problems, the British Medical Association, and other interested bodies, should work collectively to bring their influence to bear on government and the health professions to really make a difference. We have a blueprint for this activity from experience with tobacco, which we should learn from. What is needed is activity at multiple levels, including influencing government and NHS policy, undergraduate and professional education and training, and changing public opinion. All of these activities are consistent with the Articles of Association of the MCA, as laid down in 1969. I very much look forward to working with officers and members of the MCA to achieve those aims over the coming years.

Colin Drummond is professor of addiction psychiatry at the Institute of Psychiatry, King's College London and an honorary consultant psychiatrist at South London and Maudsley NHS Foundation Trust.

2012 National Alcohol Awareness Day poster competition

The biennial MCA National Alcohol Awareness Day competition will open on 1 November 2011 and entries must be received by 31 March 2012. It is open to UK medical students.

The competition is to design the artwork for a postcard on the theme of **student drinking**. The design must be in A5 or A6 size, and submitted electronically.

The winning postcards will be produced and distributed by the MCA. The top three will receive a cash prize to support an alcohol-related medical placement in the UK or abroad. Recent placements have been in Australia, the USA, Austria and Scotland. For more information, please visit our website – www.m-ca.org.uk/medical_students/naad_competition – or contact Sapphire.Ellison@m-c-a.org.uk.

Alcohol use in the UK armed forces

Surgeon Captain John Sharpley, defence adviser in psychiatry

Introduction

Few people will have failed to notice that armed forces personnel and their welfare are topics of wide interest, given that the UK has been engaged in military operations in the Middle East for 10 years now. The Ministry of Defence (MOD) has made the mental health of armed forces personnel an absolute priority, and this was reinforced by the new coalition government in May 2010, resulting in Dr Andrew Murrison's report *Fighting fit*, published in October that year.¹ While psychological injury tends to take centre stage, the evidence is that alcohol problems are in fact a greater problem among armed forces personnel, just as they are in the wider general population.²⁻⁴

Pattern of use

The cohort study looking at the mental health of the armed forces following deployment to Iraq (Operation TELIC) and Afghanistan (Operation HERRICK) showed that 13% of UK military personnel were misusing alcohol (alcohol use disorders identification test (AUDIT) score of 16 or more).² Even within the armed forces, there are distinct risk factors: being male; being young (25 or younger); being in the army or navy; being a regular member of the armed forces as opposed to a reservist; and being in the lower ranks. Having been deployed to Iraq or Afghanistan is also a risk factor, with 16% of regular personnel having deployed drinking harmfully compared to 11% of those who have not. Within the group that were deployed, those who were in a combat role were at higher risk, with 23% drinking harmfully, although this is explained by age and gender. Risk is also increased in those who smoke, and those who are single. However, over time there is modest reduction in the rate of those drinking harmfully, as the cohort surveyed in 2004 to 2006 shows 17% male regulars (compared with 14% in the cohort surveyed in 2007 to 2009) drinking harmfully.^{2,3}

Comparing these figures with those for the UK population show that UK armed forces personnel have a higher rate of hazardous and harmful alcohol use.^{3,5} For instance, the TELIC cohort surveyed in 2004 to 2006 showed 67% male regular personnel (and 49% of females) had an AUDIT score of 8 or more, compared with 38% of males (and 16% of females) in the UK general population.³

Comparison with US forces personnel shows interesting findings. The rates of post-traumatic stress disorder (PTSD) are relatively stable in UK armed forces personnel over the timescale of the above cohort studies, at around 4%.^{2,6} There are higher-risk groups: combat troops at 7%; reservists at 5.8%; and those medically evacuated from theatre have higher rates. In the US there is a range of rates depending on studies, but the rates tend to be higher (although where studies are robust methodologically, the rates are more similar).⁶ What appears to be different is the level of PTSD as time goes on after deployments, with US rates being higher than UK rates. With regard to alcohol problems, the situation is reversed, with UK rates among armed forces personnel being generally higher than US forces.

Cultural factors

Are there cultural explanations for the level of drinking in the UK armed forces? It may be that those who join the armed forces have a different profile to the general population – a selection bias. Those that join may be a group that perceive risk in a different way, given the obvious occupational risks inherent in military duties. The socioeconomic profile of those that join may also be different; many join from economically deprived areas. Once a person is in the armed forces they are exposed to rigorous training and cohesion building activities. The social bonding aspect of alcohol use is encouraged to a degree. Garrison, shipboard and station life all involve close-quarter living coupled with

relative affluence, as military personnel have subsidised living expenses. The cost of alcohol within military units is often less than outside, especially in overseas areas where tax is not applied. Life in the military involves many rituals, and historically these involved alcohol-related social activities. Anecdotal evidence suggests these are on the wane, but cultural patterns change slowly. On operations there is a focus on getting the job done, and in the current operations in the Middle East, alcohol is strictly prohibited, but risk appreciation is likely to be changed by personnel's experiences on operations, and this may well affect attitudes to alcohol on their return.

There is therefore a requirement for the armed forces to have clear policy on alcohol use. This is the case. All three single services have such policies that ensure commanding officers and all personnel are fully aware of the dangers of alcohol misuse, with clear advice about detecting problems. Line management and medical support are available, but being under the influence of alcohol is incompatible with being on duty. All personnel attend educational briefings every two to three years to ensure that they are aware of the requirement and consequences of problematic alcohol use. Post-incident testing for both drugs and alcohol is policy, and more recently commanding officers have been given the power to test personnel they reasonably believe are not fit for duty.

Healthcare pathway

Critical to enabling the armed forces to manage alcohol misuse is flexible and rapid access to appropriate care for those with alcohol problems. The policies in place inform commanders of the availability of this care and encourage referral. Defence Medical Services provides comprehensive primary care and mental healthcare. Personnel may present to primary healthcare with specific concerns about their alcohol use, physical problems (including injuries

National Annual Michael Frowen Essay Competition 2011–2012

Alcohol guidelines: who, what, why, where, when?

The UK government has recently consulted interested parties on the evidence base for alcohol guidelines. There are many issues to be considered, such as the rationale for guidelines, the evidence for their effectiveness, the need for different guidelines for different groups, and experiences with alcohol guidelines in other countries.

Word count must not exceed 3,000 (references and title not included). Harvard referencing style must be used.

The winning essays will receive:

1st place: £500

2nd place: £300

3rd place: £200

In addition, winners will be invited to attend the 2012 AGM and CPD-approved seminar and be awarded a signed certificate. The first-placed essay will be published in the MCA Annual Report and there will be the possibility of publication in a peer-reviewed journal for the winning essay.

To apply, send your essay to: The Medical Council on Alcohol, 5 St Andrews Place, London NW1 4LB
Or alternatively via email to mca@medicouncilalcol.demon.co.uk Entrants must be current medical students in the United Kingdom The closing date is 30 April 2012

or mental health issues secondary to alcohol use), or may be regular attendees with minor health problems. Primary care facilities will manage simple alcohol problems with assessment and brief interventions, or refer to one of the departments of community mental health (DCMH). There are 15 DCMHs around the UK, generally in areas where there are concentrations of military personnel. Each is staffed with community mental health nurses, psychiatrists with access to psychologists, and mental health social workers. About 5,500 new referrals were seen in these DCMHs in 2010, of which 3,900 were diagnosed with a specific mental disorder.⁷ The relatively high rate of non-diagnosis reflects the occupational nature of military psychiatry, where fitness for duty is often a concern of primary care referrers. Of those with a diagnosis, 293 had a primary diagnosis of alcohol use disorder. As secondary diagnosis is not recorded by Defence Analytical Services and Advice, it is not possible to ascertain the true level of alcohol use disorder among those referred to DCMHs.

Assessment at a DCMH involves looking at an individual's alcohol use, any comorbid mental health or physical problems, clinical risk, their occupational functioning and risk.

The assessment of their occupational functioning is aided by the production, where consent is given, of an executive report on their performance, written by their line manager to accompany their referral. Many will then be discussed in the DCMH multidisciplinary team meeting, and a plan of care will be formulated that may include brief intervention, motivational interviewing, cognitive behavioural therapy, relapse prevention work, or an alcohol support group. Psychiatric involvement will occur if medication or detoxification is necessary, the latter usually occurring in the community. Some DCMHs offer educational groups, and there is currently a randomised controlled trial underway looking at the effectiveness of a one-day alcohol education course. Inpatient care is available for detoxification in those cases that require it. The inpatient care for armed forces personnel has been outsourced to external providers since 2004, when the last military psychiatric inpatient unit closed. Currently inpatient care is provided by a consortium of eight NHS trusts around the UK, headed up by the South Staffordshire and Shropshire NHS Foundation Trust. In 2010, 254 patients had inpatient care, and 19% of these had an alcohol use disorder.⁷

Rehabilitation back to operational fitness is a key aim of mental healthcare of armed forces personnel. Everybody in the armed forces has a medical fitness category, which is altered if they present for treatment or have a condition that limits their fitness or their deployability. There is a wide range of fitness categories and many specified duties that can be limited – or not, as the case may be – which allows for the construction of a graded return to work capability.

The future: issues and initiatives

The MOD has recently reviewed its approach to mental health and healthcare, and there are several initiatives being taken forward to improve the management of alcohol problems. Making sure policy is adhered to is a key issue, as well as understanding the effect on operational capability of the forces as a whole, which drives work in both mental health and physical disorder areas. Determining the best ways to influence personnel risk of higher levels of alcohol problems on return from deployments is another issue. A recent study into post-operational briefings looking at a UK version of Battlemind (a US form of stress briefing) showed a modest effect on reducing harm due to alcohol use.⁸

Improving knowledge of alcohol use disorders and their management in the primary care setting has been a concern which has driven the provision of some primary care 'masterclasses' on this subject. Ensuring that all DCMHs have the right skill set to manage alcohol problems is leading to efforts to ensure that all nurses have motivational interviewing skills, and that each DCMH has an alcohol nurse specialist. The recently codified Armed Forces Covenant represents acknowledgement by the government that serving personnel and their families, as well as veterans, need recognition for their service and must not be disadvantaged by their relative mobility as a result of service. Alcohol problems are recognised in this and leads to the requirement for healthier relaxation facilities, as well as adjusts the alcohol testing arrangements noted earlier.

The recommendations of Dr Andrew Murrison's report *Fighting fit* are being implemented currently. These include, for serving personnel: a post-operational screening study to look into the effectiveness of screening those returning from operational deployments for mental health problems; instituting a structured mental health assessment in routine medicals that all serving personnel undergo at various times during their service; adjusting policy to allow personnel who leave the armed forces to attend DCMHs for up to six months after they have left; and access to a free online mental health support service (www.bigwhitewall.com). For veterans there is an uplift of mental health personnel to create outreach services to encourage veterans into mental healthcare; a 24-hour telephone support line operated by Rethink and Combat Stress; e-learning for NHS GPs on veterans' health issues; continuation of the Reserve Mental Health Programme (a service for those demobilised as reservists who have

served on operations since January 2003) and the Medical Assessment Programme (a service for any veteran serving since 1982 with concerns about their mental health). The online support service is also available to veterans and families of both serving personnel and veterans.

Much is being done to improve the mental health of the UK Armed Forces, and while it would be wrong to suggest that personnel in the armed forces generally suffer higher rates of mental health problems than the general population, their service does involve specific occupational risks and there is a key issue with alcohol problems, making this work highly appropriate.

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- ▲ Roger Penwill is a cartoonist and illustrator whose work has been exhibited worldwide. He has been producing cartoons for the MCA since 1979. Here's his own take on the perils of overindulging during the festive period!

The Medical Council on Alcohol is a small national charity committed to improving the medical understanding of alcohol-related problems.

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