Editorial

The damage caused by alcohol in our society can hardly be overstated. Twenty-five per cent of all hospital-related admissions related to alcohol misuse; increasing levels of alcohol-related crime and domestic violence; rising levels of antisocial behaviour occupying inordinate amounts of police time – all of which translate at a personal level to a huge burden of misery for those affected and their families. Moreover, the problems seem to be getting worse, suggesting that a change in tack to the way we deal with alcohol misuse as a society is overdue.

It is therefore refreshing to read several articles in this issue that reflect recent developments in thinking about the way people with alcohol misuse issues can best be helped. These involve a move away from specialist treatment centres and towards recovery in the community. As well as providing good, factual information, these articles should prompt therapists to think in broader terms when it comes to treating people with alcohol issues.

David Best and Angela Campbell describe how the recovery movement in mental health and drug addiction has led to a re-framing of the role of addictions treatment. In this model, recovery takes place primarily in communities, triggered and sustained by supportive relationships and jobs, peer and community support groups, and therapeutic relationships that can act as the basis for change through building motivation, encouraging positive life skills, and acting as a bridge to community support.

Continuing on the theme of community-based support, David McCartney outlines the thinking and development of mutual-aid groups in maintaining recovery, arguing that practitioners need to understand and use these groups to help clients. This seems particularly important, as the benefits of such groups are widely seen as acceptable by clients, but less so by practitioners, with only one-third facilitating client access. Particularly useful are his outlines of the 12-step programme of Alcoholics Anonymous (AA), and of practical techniques to enhance the benefits of these groups to clients. These should help practitioners – and clients – to make use of this massive resource, which far outstrips the capacity of statutory services' treatment provision.

Alex Copello also focuses our attention on the context of clients' lives, arguing that a shift in the way we understand addiction problems must incorporate the family – and that 'thinking family' can make a significant contribution to practice and to improved outcomes in the field.

Factual knowledge can assist therapists in helping clients, and Richard Allsup usefully outlines the physiological effects of alcohol intoxication, dependence and withdrawal. In viewing alcohol misuse as a behaviour and not an illness, he describes an interesting process model of why people drink. Change occurs when a person develops awareness of how they restrict themselves, the capacity to tolerate the depth of their feelings, and sufficient safety to 'experiment' with different ways of relating to themselves and others, he argues. The therapeutic alliance is a valuable tool for enabling this change.

After six enjoyable years' editing *HCPJ*, I am away on sabbatical for the next 12 months. My best wishes go to Sarah Hovington, primary care counsellor, BACP Healthcare Executive member and *HCPJ* Associate Editor, who is taking over as *HCPJ* Editor. Finally, I would like to thank Sarah Browne, BACP Head of Journals, who appointed me to care-take *HCPJ* all those years ago, and all of you, for supporting *HCPJ* – and for your interest and enthusiasm in practising and promoting psychological therapies in healthcare settings. Long may it continue!

Penny Gray, Editor

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