

RCAS (Rotherham Community Alcohol Service)

The principles that should underpin the strategy

Our starting point is one of principle. Before considering how best to tackle the problems associated with alcohol misuse we need a clear understanding of why Government should play a role at all.

1. Why should the Government get involved in managing the harmful effects of alcohol misuse? At what point does Government intervention become justified?

The Government are already involved in managing the harmful effects of alcohol misuse and have been since at least the early seventeenth century. At that time the issue was not with drink per se (the main drink being beer which was safer to drink than contaminated water) but with drunkenness. Cheap imported gin and the growth of an industrialised brewing industry in the nineteenth century coupled with the new mass of working class urban poor made a drink problem to which society had to respond. This eventually came in the form of a limit to the number of liquor outlets, annual licensing and a reduction of the tax on tea, coffee and sugar in 1834; the outcome of a parliamentary committee chaired by James Buckingham. Numerous Acts of Parliament preceded and have followed.

2. How far is alcohol misuse a matter of individual responsibility and when does Government have a responsibility to intervene, whether through services, legislation or persuasion?

In the liberal democratic state which we live in it is not unreasonable - to paraphrase J.S Mills - to state that the individual is sovereign in his rights over his own behaviour; the only point at which others have the right to interfere is to protect themselves or other people. This begs the question of the extent to which a person has the ability to make independent choices when s/he is intoxicated. That argument justifies a degree of intervention at an individual level. At a government level there are many circumstances in which intervention may be justified: to protect public safety; to protect the rights of others; to protect the quality of life of others and their surroundings.

3. How can we strike a balance between individual and community rights and choices?

One theoretical view about the starting point for what became modern society is the idea that individuals had a better chance of survival in life by banding together and pooling their resources to create some form of community. As communities and societies grew larger individuals were less able to take part in decision making and they delegated these powers to an authority to make decisions for the common good. These usually take into account factors such as public health, public safety, best use of resources and the restrictions on behaviour which are a cost to society. A logical and effective alcohol policy has to take into account the delicate balance of individual freedoms and responsibility that come with living in an interdependent community.

4. What are the respective roles and responsibilities of consumers, voluntary groups, commercial interests and others?

There are a range of conflicting values, beliefs and vested interests which make the policy maker's task a difficult one. Alcohol consumption is part of a European tradition and is deeply embedded in British culture. Most people in the UK drink and the most popular leisure activities away from home are visiting a pub and having a meal in a restaurant (Office of National Statistics, 1998, p221).

The ethical marketing of a product such as alcohol that has beneficial and harmful effects is bound to be difficult. However profit, market share and globalisation drive their commercial interest and will only be restrained by legislation. Brewers and distillers bring benefits to the economy and individuals derive pleasure from drinking, but alcohol is a factor in a wide range of health and social problems.

Voluntary groups working in the fields of properly funded prevention and treatment invariably rely on public money (with the notable exception of Alcoholics Anonymous). The responsibility of helping agencies is to deliver services that are of demonstrable quality, value for money and use the skills of adequately trained staff working with knowledge based/evidence based approaches.

5. What principles should underpin a national alcohol harm reduction strategy?

A harm reduction approach should seek to both prevent harm from alcohol misuse and respond to reduce and alleviate its effects. The following principles should underpin the strategy.

Integration: Alcohol problems do not exist in isolation: they are related to other problems that the Government has started to tackle (and the alcohol strategy will contribute to the alleviation of), for example, social exclusion, poor housing, poverty and community safety. Therefore a coordinated, wide ranging response is required in order to maximise the potential of reducing harm in a sustained way.

Long term perspective: This strategy should take a long term view of the benefits of reducing harm and view financing of prevention initiatives and treatment as a long term investment with a justifiable cost/benefit analysis.

Accountability: Specific, measurable, achievable, realistic and timed outcomes/expectations should be set for the strategy. Interventions (prevention or treatment) should be knowledge/evidence based and targeted to provide the best long-term sustainable achievements.

The cultural and behavioural issues around alcohol use and misuse

Alcohol misuse and its impacts play out against a wider canvas of behaviour and attitudes related to alcohol: we need to understand this wider picture in order to understand how to influence and reduce harmful effects.

Questions

6. How do you define alcohol misuse? What factors do you take into account?

Alcohol misuse can be defined as drinking problematically or hazardously in physical,

mental and/or social terms. This might include:

- drinking consistently in excess of DoH sensible drinking benchmarks
- drinking in circumstances which aggravate an existing condition or situation
- drinking in such a way as to endanger the drinker or others or cause a nuisance.

7. What drinking patterns should an alcohol harm reduction strategy seek to affect? How susceptible are such patterns to change? Where should Government concentrate its efforts in prevention?

Alcohol-related problems must be addressed at the broad population and community level. Policies that focus on the heaviest drinkers are unlikely to succeed. The amount of alcohol related harm within a society associated with a particular level of drinking is a product of both the risk and the numbers of people drinking at that level. Paradoxically this means that moderate levels of risk can result in greater harm because more people are drinking at these levels. The aim should be not just to target heavy drinkers, but to reduce the levels of drinking in the very large number of people who would be called moderate drinkers.

Drinking patterns are susceptible to change: they are responsive to social pressures and fashion. The drinking habits of children and young people are important as predictors of subsequent problems eg problem drinking and in some problem drug use. Weekend binge drinking among 16 - 25 year olds is a locally identified problem.

8. Is there a relationship between trends in drinking and wider social changes – e.g. the spread of higher education, changes in workplace culture, later marriage and/or family formation? Where does this suggest we need to focus attention in influencing behaviour?

The spread of higher education has brought with it the ubiquitous university and college bar selling low price drinks, peer groups supportive of heavy drinking, unfamiliar social and academic pressures. Concurrently the alcohol industry has introduced and promoted high-alcohol-by-volume sweet tasting and stylishly marketed fruit wines, spirit mixers and strong ciders. Changes in workplace culture have encouraged more responsible drinking: the demise of heavy industry with a heavy drinking tradition and the increase in workplace alcohol policies.

The focus of attention should be on encouraging socially responsible drinking.

Educational achievement is undermined by excessive drinking. Consumption of alcohol is price-elastic, therefore high alcohol by volume drinks should be taxed punitively or made less affordable. Retailers of alcohol could play a more responsible role in the selling of alcoholic drinks to already intoxicated purchasers. It also might be useful to encourage soft drinks at lower prices and discourage 'happy hours'.

9. One group we need to focus on specifically is young people, where the evidence suggests a rise in consumption, particularly by young women. Are there other groups we should be focusing on? For example are there specific issues around minority ethnic attitudes to, and use of alcohol which we should bring into our analysis?

Drink drivers: Random breath testing could make a significant difference as part of a preventative strategy.

Older people: This is an overlooked group susceptible to decreased ability to metabolise alcohol and increased vulnerability to alcohol related accidents.
People in hospital: 25% of male admissions have an alcohol contributing factor.
Hospitalisation may additionally precipitate detoxification. People in hospital are a captive audience for a wide variety of health promoting messages.
Occupational groups: We know that some occupational groups have a higher incidence of alcohol related morbidity and mortality than others, eg. Publicans, Deep sea fishermen.
Drinking amongst minority communities whose cultures consumption of alcohol is often hidden and discussing the problem is taboo. Sensitive, culturally appropriate specialist services to help the drinker and support the family of the drinker are required. There are many examples of these which the University of Central Lancashire may be able to advise. Our minority community in Rotherham is served by a specialist agency called Saaf Dil, which is part of Rotherham Community Alcohol Service (RCAS).

10. It is easy to focus on the negative aspects of alcohol use and misuse. But what are the positive cultural and behavioural (as opposed to economic) aspects? What parts of our culture would change for the worse if we did not have alcohol?

The public house as focus for village (and TV soap) life; architectural inheritance; popular pastime and tradition. Alcoholic drinks as a complement to food; social lubricant; de-stressor. It is useful to note the track record of societies that have tried to ban alcohol and learn from the mistakes that were made in their attempts.

11. Is there such a thing as a recognisably English drinking culture and if so what does it look like? What are the factors which influence it – for example are there sharp regional differences? Does it look different for different ages groups?

There are many facets to English drinking culture; the village pub; the gentleman's club; and more recently the booze cruise and car boot/white-van sales outlets.
The factors that influence drinking culture, including age and region are best understood by viewing the community as a dynamic, complex and adaptive system. Prevention strategies historically have been single solutions, ie a single large initiative or programme rather than a number simultaneous mutually reinforcing approaches. These can be subtle in nature, seemingly slow in their effect, but ultimately high impact and long lasting.

12. What factors influence behaviour – fashion and marketing, family background, education and information, financial, legal and regulatory, scientific, environmental? Which are the most influential in your view? How easy is it to exert influence through those factors?

All of the above and the media, particularly television: sports sponsorship; advertising of alcoholic drinks both on television and static sites (billboards etc).

The most influential - in order of when they affect the person as s/he is growing up are:

- (1) the attitudes and patterns of drinking of parents/guardians
- (2) the influence of peers
- (3) the acquisition of social and interpersonal skills (eg for dealing with peer pressure) and building of self esteem
- (4) the amount of disposable income
- (5) the price and availability of alcohol

13. How do attitudes to risk affect use of alcohol?

Alcohol is a disinhibitor. Therefore those people who are predisposed to take risks will be significantly more likely to indulge in risky behaviour; and those who were less likely to take risks will be more likely to do so under the influence.

One obvious example of this is sexual behaviour. We know that teenagers are 3 times less likely to use a condom after 5 drinks than non-drinkers and that the subsequent risk of pregnancy or acquiring a sexually transmitted disease is increased. Research also shows that homosexual men who increased their alcohol use are more likely to maintain high-risk sexual practice than those who reduce their drinking.

Health: prevention, treatment and the impact on the NHS

The effects of alcohol misuse cost the NHS money. There are direct costs both to the NHS and in social care in treating those with alcohol dependence. And there are a host of indirect costs through alcohol-related illnesses and accidents; through violence fuelled by alcohol; and through mental illness and depression associated with alcohol misuse; and through the mixing of alcohol with illicit drugs. But there is also some evidence that moderate alcohol use for some groups can be beneficial to health.

Questions

14. How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become problematic drinking

The alcohol literature contains a large number of terms used to describe alcohol use. It is not helpful that these are not consistent.

The General Household Survey (Office of National Statistics 2000) categorises -
Light/moderate drinking as: men drinking below 21 units: women below 14 units per week.

Heavy drinkers: men drinking 22-50 units/week; women drinking 15-35 units/week

Very heavy drinkers: men drinking 51+ units/week: women drinking 36+ units/week.

A 'harmful drinker' is one where there is clear evidence that alcohol use is responsible for (or substantially contributes to) physical or psychological harm, including impaired judgement or dysfunctional behaviour, which may lead to disability or have adverse consequences for interpersonal relationships.

15. How clear is the evidence both for the health costs and the health benefits of alcohol? Are there key pieces of research of which we should be aware? Where are the gaps in the evidence?

Health costs are well researched by York University's Health Economics unit. Up to date figures may be available from there (particularly Christine Godfrey/Alan Maynard). The following was compiled in 1992 (Godfrey & Hardman, 1994)

Sickness absence cost to industry	£1059m
Unemployment	£ 244m
Premature deaths	£ 956m
In patient costs (direct alcohol diagnosis)	£ 41m

" " " (related alcohol diagnosis)	£ 120m
General Practice costs	£ 3m

	£2423m

The principal economic benefits relate to trade and employment, with the drinks industry employing approximately 43,000 people in 1994 (source: Brewers & Licensed Retailers Association/Office of National Statistics 1997). In 1996 the industry delivered a positive UK trade balance of £893.6m. In 1996/97 the government revenue from alcoholic drinks was £10,037 million ie 4.8% of total tax revenue (Alcohol Concern Information Unit factsheet 22) The cost of consumption includes the home-brew market.

16. What are the costs for the NHS both directly and indirectly due to alcohol? We will be examining evidence on this but would welcome your views and any evidence you think we should be aware of.

Financial costs listed above; further information available from Christine Godfrey, Professor Alan Maynard, Health Economics Unit, University of York.
 Indirect costs to NHS: absenteeism in a large workforce; costs of repeat treatment in the absence of a targeted early intervention; lost opportunity costs to those whose drink problem goes undetected and results in complex health and social problems.

17. What, in your experience, are the most appropriate means of prevention of alcohol dependence and serious alcohol misuse? What forms of training are most appropriate for professionals in health and social care, as well as other fields, who play a role in prevention.

The best form of prevention is to equip young people with information about alcohol to assist them to make informed choices about drinking; to develop their interpersonal skills (eg assertiveness, ability to resist peer pressure) to facilitate them to enact those choices; build their self esteem to enable them to use the knowledge and skills and encourage an attitude to drinking that is health enhancing and socially responsible. Teachers and parents have roles and responsibilities here, as do the media and the drinks industry. To prevent alcohol dependence and serious alcohol misuse early interventions in alcohol problems are required. Therefore, it is imperative that alcohol problems are recognised and responded to by the largest range of professionals that come into contact with the problem drinker. The training required is recognising a problem, raising the issue of misuse and making an appropriate referral. Underpinning these skills it is necessary for the referrer to be non-judgemental and confident about the person overcoming their problem.

18. "Brief interventions" can be offered to patients who have been identified as at risk from alcohol misuse. They may consist of a short session with a doctor or nurse to discuss a patient's drinking and to offer help and support to cut down on alcohol intake, if the patient wishes to do this. How effectively do you think those at risk are identified? How well have you found brief interventions to work and how might they work better?

Professor Nick Heather at Plummer Court, Newcastle is the authority in the area of brief

interventions, their effectiveness and success rates at follow up.

Early identification is the key: recognising an alcohol problem then raising the issue and intervening. Identification ought to be relatively straightforward with the range of screening tools available (questionnaires, breathalyser, blood tests). If the problem is not the recognition it may be raising the issue of alcohol use: this is still seen as an intrusive personal question and if the person asking the question does not have the training to follow through with a brief intervention or the information where to appropriately refer, it is not surprising that the presentation is recognised but not investigated. The above knowledge and skills assume that the attitude of the nurse or doctor is positive/empathic to problem drinking; this may not always be the correct assumption. Equally a recent article in the British Medical Journal found that G.P.'s felt that brief interventions harmed their rapport with patients and were not welcomed by patients.

19. Do current treatments for alcohol dependence and hazardous drinking work? Are they sufficiently tailored to meet differing individual needs? Are there other forms of treatment we should be aware of? Is there a need for guidance for the commissioners of local treatment services? How should individuals best access treatment services?

Project MATCH in America and NTORS in the UK provide affirmative evidence that treatment works. Quality in Alcohol and Drug services (QuADS) provides a quality assurance tool which ensures that individual's treatment needs are addressed through care planning.

A local initiative which our multi-disciplinary team developed recently in response to temporary restricted availability of inpatient beds for detoxification from alcohol, is a 5 day supported detox run by our community nurses (under the direction of the Substance Misuse Consultant Psychiatrist) at our street agency. Small groups (4 to 6 people), appropriately assessed, receive symptomatic relief medication and diversionary recreational activities from 9am to 5pm, Monday to Friday. Breathalysed every day to encourage compliance, each cohort quickly becomes mutually supportive and therapeutically sustaining. Antabuse and Campral are available to sustain abstinence if requested at the end of the detox. Success rates so far are good and we hope to follow up at 3 and 6 months.

Problematic drinking is socially stigmatised. Most people delay seeking help for problematic drinking (as they do for many other difficulties). The range and availability of self help materials (literature, video, interactive computer software) could be increased. Also remote anonymous internet access may enable early self-directed interventions. More information could be made available for families of problem drinkers.

Need for guidance for commissioners: minimum purchasing and commissioning guidance for specialist alcohol services; advice about coordination of treatment services.

Funding/advice for needs assessment of populations; translation of this information into predictions about numbers of people seeking help at tier 1-4 services per annum. Finally advice about the viability and value of medium to long term contracts (3-5 years).

Access for individuals: better public information of range of sources of help; options 1:1 and group interventions; options of controlled drinking and/or abstinence; services could do more to break down barriers to accessing treatment eg. drop-in assessments, open

days, walk in entry.

20. What can we learn from drugs prevention and treatment?

Earliest possible information provision eg. primary school

Target at-risk populations

Treatment is proven to be effective

Sometimes coercion is necessary as a pump primer to getting people into treatment

Early interventions

Offer a range of treatment options

We need baseline information about knowledge levels and levels of drug use if we are to set realistic, measurable targets for effectiveness.

21. How, in your experience, can we minimise and prevent the injuries that are presented to A&E departments as a result of alcohol related assaults (often with glasses and bottles) or home and workplace alcohol-related accidents?

Reducing alcohol related assaults:

- glasses that shatter on impact or plastic glasses; no bottles/frequent bottle collection inside the premises and from rubbish bins outside.
- pubwatch/door supervisor schemes.
- server training to enable refusal to serve intoxicated people.
- identifying hot spots/premises that are repeat offenders; licensing restrictions/rewards for well managed premises
- understanding relationship between clubs, pubs, fast food outlets, public transport.
- Local licensing influence over opening hours, happy hours, proof of age scheme and test purchasing.

Reducing home and workplace alcohol-related accidents:

- better public information linking effect and cause/role of alcohol
- employee assistance programmes
- workplace alcohol and drug policies
- clear, consistent responsible drinking messages.

22. What are the links between alcohol misuse and mental health problems, including depression and suicide? How are services – both those aimed at prevention and treatment – best co-ordinated?

People with concomitant mental illness and alcohol misuse problems are among the most vulnerable in the community. When compared to people with a mental health problem alone, people with dual diagnosis are more likely to have: increased suicide risk; more severe mental health problems; homelessness and unstable housing; increased risk of being violent; increased risk of victimisation; more frequent contact with the criminal justice system; family problems; history of childhood abuse; more likely to fall through the net of care. Long term alcohol misuse is associated with conditions such as Korsakoff's syndrome, Wernicke's encephalopathy, delirium and seizures. A study by Regier et al (1990)* found that 37% of those with an alcohol disorder had another mental disorder.

Service coordination: The Mental Health National Service Framework clearly states that the primary responsibility for the treatment of severe mental illness lies with mental

health trusts and specialist services (standards 4+5). The Dual Diagnosis Good Practice guide indicates that mental health services are primarily responsible for people with mental health and substance misuse.

*Regier et al (1990) 'Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiological Catchment Area (ECA) study'. Journal of the American Medical Association 264(19) pp 2511-2518.

Crime, disorder and anti-social behaviour: the effects on our surroundings and community

The most visible effect many of us see from alcohol misuse is in our town and city centres: pavements littered with broken bottles and streets too intimidating to pass through. Links between alcohol and disorder are as much a matter for concern as are links between alcohol and crime.

Questions

23. What evidence is there about the links between alcohol and crime and the links between alcohol and anti-social behaviour? Are there key studies or pieces of evidence you think we should be aware of? Where are there gaps in the evidence?

The Home Office document "Tackling Alcohol Related Crime, Disorder and Nuisance Action Plan" (2000) states that "alcohol contributes significantly to crime levels, through alcohol specific offences. Offences against licensing laws, offences committed under the influence of alcohol. It has been estimated that 40% of violent crimes, 78% of assaults and 88% of criminal damage cases are committed while the offender is under the influence of alcohol". Crime and disorder partnerships throughout the country conduct local crime audits and over 70% of them identify alcohol as an issue; over 40% highlight drunkenness as an issue and 60% relate public order problems to alcohol. In Rotherham our criminal justice worker conducted a small survey of alcohol related detention at our local police station and found that over 60% of people detained had been drinking just before the offence was committed. The links between alcohol and crime were explored in the Crime Reduction Research series, Paper 3: "Alcohol and Crime, Taking Stock" (Home Office Research, Development and Statistics Directorate 2000). Anne Deehan, Tracey Budd and Trevor Bennett are authorities in this area and ideally placed at the Home Office to inform the strategy.

Gaps in the research base might include: the effect of liberalisation of the licensing laws on crime and disorder; the true level of drink driving (and drug use) on Britain's roads; the refining of the measurement and recording of alcohol-related violence and disorder.

24. In your experience, is alcohol a factor in habitual re-offending? Does it lead to particular types of crime? How far does it lead to one-off offences?

The relationship between alcohol and crime is complex. Alcohol influences crime directly and indirectly. Alcohol directly triggers some crime such as some public disorder. It indirectly influences other crime by, for example, providing a motive (in

acquisitive crime); lowering inhibitions/impairing judgement (in urinating in a public place); by providing a false sense of invincibility (in some violent crime); by enhancing negative mood (in some cases of domestic violence).

25. To what extent can alcohol convincingly be demonstrated to be a factor in criminal and disorderly behaviour? How much is perception and how much is reality? What fuels the perceptions and are they accurate?

Identifying the precise role of alcohol in offending is difficult, however, it has been estimated that 40% of violent crime, 78% of assaults and 88% of criminal damage cases are committed under the influence of alcohol. There is no simple causal relationship; the necessary comparison and control samples cannot be obtained. However, it seems clear that it is a consistent precursor of offending behaviour. Alcohol is inextricably linked to disorder around licensed premises. The difference between perception and reality of alcohol related crime and disorder is that those who have been the victim of alcohol related violence (a quarter of those contacted by MORI in a survey commissioned by the Portman Group in 2000), preferentially recall the violent incident they experienced rather than the many other peaceful exchanges that they experienced that evening and other evenings. However, this does not mean that the perception is wrong or inaccurate. The level of alcohol related crime and disorder is too high, particularly in city centres on Friday and Saturday evenings. There are around 5000 'glassings' each year in which a smashed beer glass is used as a weapon. Up to 1000 young people each week suffer serious facial injuries as a result of drunken assaults - 18,000 young people are scarred for life each year (Institute of Alcohol Studies fact sheet; Alcohol and Crime 2001). This is not an issue of perception.

26. Alcohol is far from being the only factor in crime and disorder. Other factors are involved – for example town centre disorder can be influenced by lack of availability of transport or design of environment. What other factors might be involved? How easy are these factors to influence? Who is responsible for them?

Fast food outlets: intoxicated and disinhibited people queueing for food.
Density of pubs in one area leading to a culture where drinking is encouraged, even fostered.
Dim lighting, dark alleys/snickets.
Litter, noise, poor facilities, restricted public toilet facilities.
These built-environment factors are relatively easy to influence by partnerships whose responsibility it is to address crime and disorder. Solutions include monitoring hot-spots, installing CCTV, improving lighting, improving facilities and public transport.

27. How does the impact of alcohol on urban environments differ from its impact on rural environments? What are the differences between urban and rural drinking patterns and how do they affect those communities and surroundings?

The village pub often provides the sole focus of entertainment in rural communities. Rural communities have been traditionally viewed as being more cohesive, but is this still the case with an increasing level of town worker dormitory occupation? Policing of rural areas may be less intensive than urban areas leading to less strict licensing observance and increased drink driving.

28. To what extent can impacts on the environment (including crime, disorder, noise and waste) be designed out, for example by use of plastic drinking glasses? Are there examples of good practice it would be helpful for us to be aware of?

Solutions to the built environment have been mentioned at question 26. However, the brewing and retailing industry have a role to play in reducing public drunkenness by

- refusing admission to licensed premises to known troublemakers
- refusing to sell alcohol to the already intoxicated
- avoiding crowding, changing poor bar layout, improving customer traffic flow
- discouraging discount drinks and promotions that encourage heavy drinking
- more widespread "proof of age" schemes
- better server training
- more door staff
- new powers for the police to close disorderly premises.

29. There are some examples of good practice where a range of organisations responsible for dealing with different aspects of alcohol have successfully 'combined efforts' and shared information to tackle alcohol-related crime and disorder together. Should this approach be encouraged more widely? What inhibits organisations or communities from taking such an approach?

Combined efforts are useful, especially when consistent information is gathered, shared and acted upon. This can be useful not only in the identification of hot spots (poorly managed premises) but also in the identification and apprehending of bootleggers. Rotherham police have been recently commended in a local review by Alcohol Concern (unpublished, available from Safer Rotherham Partnership).

30. Is it right that anti-crime and anti-social behaviour initiatives need to be targeted on young people?

One would need to examine all the evidence before that conclusion was reached. Young people, especially the underage, are a vulnerable group, as their inexperience of drinking and lack of tolerance to alcohol means that they become intoxicated more quickly. However it should be noted in the context of the response to question 11 that a single strand (tough on crime, tough on the causes of crime) approach will be less effective than a multifocused solution. If young people's alcohol fuelled behaviour is a problem, part of the solution may lie in the provision of alternative (alcohol free) facilities and activities.

31. Should we be encouraging different drinking patterns – in terms of time spent drinking, location of drinking etc – in order to tackle alcohol-related crime and disorder?

In short - yes. However, a single strategy even if it is multi-pronged should not be used in isolation. A strategy to change drinking patterns must sit in the context of better education about alcohol and improved interpersonal skills; earlier interventions in alcohol related problems and changes to the way licensed premises are managed. Furthermore controls to the promotion of alcohol (portrayal of drinking in the mass media and advertising); changes to taxation and pricing (there is a direct relationship between affordability and percapita consumption); and changing public attitudes by education

campaigns and the use of positive role models will also contribute to the overall aim of reducing individual consumption to moderate and responsible levels.

32. How can the law on, and policing approaches to public drunkenness and street drinking help to tackle these problems? Are existing controls and powers (such as those for local authorities to introduce no drinking zones) effective? Are they sufficient?

The Crime and Disorder Act 1998 gives local authorities new powers for managing anti-social behaviour, eg Anti Social Behaviour Orders (ASBOs) and Acceptable Behaviour Contracts (ABCs). The use of these powers could be encouraged. No-drinking zones and confiscation of alcoholic beverages, allegedly just pushes the problem to a different part of town. Perhaps use of new laws and talk of acquiring even more powers is an indication that we are not getting this right at a fundamental level, or perhaps it supports the point made in the previous responses that a simple solution to a complex problem will have a restricted chance of success.

33. One person's good evening out can be another person's sleepless night. Are there principles to guide the balance of individual rights and responsibilities?

Ethical Principles:

- All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
- All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
- All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and to the extent possible, from the promotion of alcoholic beverages.
- All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
- All people who do not wish to consume alcohol, or who cannot do so for health reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour. Source: World Health Organisation: European Charter on Alcohol.

34. Drink-drive policies are generally acknowledged to have been successful. What can we learn from them?

Media campaigns such as drink driving appear to be more successful when they target specific risk-taking groups (Murray, Stam, Lastovicka: Evaluation of an anti-drinking and driving campaign with a sample survey and time series intervention analysis, 1993). The received wisdom has been that fear arousal techniques don't work. On the whole, empirical evidence supports the use of fear arousal, providing that the advertisement includes a reassuring message and specific guidance on the action required to avert the risk. (Sutton and Godfrey: A grouped data regression approach to estimating economic and social influences on individual behaviour. published in Health Economics 4, pp 237-247, 1995).

35. Domestic violence is often associated with alcohol misuse – either by the perpetrator, or, on occasion, by the victim. What in your experience, is the nature of

this link and what would you see as good practice in tackling the interrelationship between domestic violence and alcohol misuse?

We know that alcohol is a factor in 40% of domestic violence cases. If part of the role of alcohol in these cases is to disinhibit the aggressor (or the victim) then the underlying tensions may be connected with mistaken expectations/assumptions about gender roles; frustrated personal ambition/achievement; learnt incorrect behaviour from role models in childhood.

A colleague adds "Research shows that violence in a domestic setting is clearly a gender issue. Overwhelmingly women experience violence from men. Some women report that the man often drinks as a precursor to the violence but alcohol does not cause it.

Attempts to uncover or explain what has led up to or caused a man's violence do not acknowledge his responsibility for his actions. Men who perpetuate violence against women do so in order to control and dominate the woman, control the rules of the household and punish women for asserting themselves. It is clear that violence is functional and men make personal choices to be violent. This violence occurs in a context where communities and institutions can collude with the violence for example by accepting excuses for it such as alcohol misuse".

There is no excuse for domestic violence, but in endeavouring to address it there must be clarity about its cause. It is only then that these can be addressed both in the home and in school. In an ideal world all young people would grow up with the ability to distinguish right from wrong and the interpersonal skills to express themselves in non-violent (and non-offensive) ways. Clearly these interpersonal skills (as with others mentioned all the way through this document) rely on adequate levels of self esteem and self awareness.

The implications for vulnerable groups

Some people may be more vulnerable to the harmful consequences of using alcohol. Certain groups of young people in particular are at higher risk of developing a range of difficulties that include alcohol-related problems (for example children in social care, those excluded from school and youth offenders). Families and carers can play an important role in protecting young people from problems but it is important to recognise that living with a parent or carer with an alcohol problem can itself become a source of vulnerability.

Questions

36. Which children and young people do you see as being most vulnerable to the consequences of alcohol misuse?

Children and young people who are already at risk, ie those on the At-Risk Register.
Children and young people put in the role (or adopting the role) of carer themselves.
Children and young people who are being abused or neglected.
Children and young people involved in the sex industry.
Children and young people who have no support networks.
Children and young people excluded from school or who are truanting.
Children and young people with learning difficulties.

Children and young people with low self-esteem/self-efficacy.

37. What other groups would you identify as particularly at risk and vulnerable to the harmful effects of alcohol?

Students: college and university bars sell cheap alcohol in a peer-supported culture of excessive drinking and a context of unfamiliar academic and social pressures.
Homeless people: Many are excluded from health and social care services, exposed to the elements, thieves and bullies; and are often suffering mental health problems and physical health problems.
Prisoners and those leaving prison: Although probably not drinking while incarcerated, up to 30% would have been problem drinkers before they went into prison and between 30% and 60% claim to have offended whilst under the influence.
Older people: A recent report from Age Concern highlighted this often overlooked group. The General Household Survey shows that in 1996 18% of men over 65 and 7% of women were drinking over the recommended limits.
Dual Diagnosis: already discussed in question 22.
Dual Dependency/Dual Treatment: people prescribed medication (especially those on methadone and those prescribed benzodiazepines) who are drinking to excess.

38. Those who are vulnerable to the consequences of alcohol misuse often have complex problems (for example they may be homeless and may have additional mental health or drugs problems) and such factors may be inter-related. What key factors need to be understood in addition to alcohol use that contribute to maintaining the problems facing such groups? Which of these factors should interventions be aimed at?

Complex problems require well thought-through, broadly based, carefully paced, long-term solutions, delivered by well supported, highly trained staff. There will be individual key factors that need to be understood that contribute to the maintaining of the problems; these will be captured in personal, social, medical, educational and occupational histories. It is not possible to generalise about the factors that the interventions should be aimed at; it may be unhelpful to do that. It is more likely that the key indicator of success is the rapport building skills and careful intervention planning of the worker, built on a starting point of mutual realistic expectations of treatment goals preferably in a harm-minimisation philosophy. Contact with the clients is likely to be long term and low output.

39. How can the services provided by the state and others to vulnerable groups with complex problems be joined-up most effectively? Are there examples of joined-up delivery it would be helpful for us to be aware of? What gets in the way of joining-up services?

We are a non-statutory street agency with a social worker, two CPN's and consultant psychiatrist input. In addition to two counsellors we have specialist projects working with street drinkers, with minority ethnic community and a probation funded criminal justice worker. What helps this work is a clear and shared value base and a skilled and motivated team. What can get in the way are different views of confidentiality; treatment modalities and priorities; different rates of pay; competitive professional aspirations;

failure to respect the contribution of different team members and unclear client care pathways. In some instances there are competing professional interests: a patient with an alcohol problem and other related mental health problems may be deemed physically well enough to be discharged from hospital but incapable of looking after his/herself in the community. This patient may be viewed as bed-blocking by one professional but vulnerable and at risk by another.

40. How realistically can these vulnerable groups be dealt with by mainstream services and how far do they need services which are tailored to individual groups and indeed to individuals on a case-by-case basis? What is your experience?

All clients/patients whether vulnerable or not should be dealt with on a case-by-case basis. The advantage of outreach workers (attached, or with direct access to mainstream services), is that their specialism is built up to a level that enables them to quickly develop the necessary credibility and skills-base to do the job. The risk is however, that their burn-out rate is high, if their case loads or case complexity are allowed to get out of manageable proportions, or the supervisory support to them is inadequate. Our experience at RCAS is that particularly vulnerable groups (such as the homeless) are best dealt with by specialist workers. For example our street drinkers worker works closely with our multi-disciplinary team and with the Local Authority Housing Department.

Education and communication

All of us receive messages about alcohol to some extent. We see advertising for alcohol and respond in various ways depending on our preferences. Information on sensible levels of drinking is also available. And messages on the consequences of getting it wrong can be clear – most obviously for drinkdriving. These are powerful tools for giving information and shaping perception. Do they alter behaviour?

Questions

41. What should be the objectives in this area? Is the aim to raise levels of awareness? Is it to inform more specifically? Is it to change behaviour? Are there any particularly successful or unsuccessful examples we should be aware of?

The aim is to encourage responsible drinking. The objectives will vary for different groups depending on their current level/pattern of drinking. For those who currently drink responsibly the objective might be to support and sustain this goal by providing basic information about alcohol. For those drinking harmfully the objective might be to help them cut down by providing basic alcohol information and advice on ways to change. For those drinking problematically, the objective is to inform them of the risks, show them what they can do for themselves and where to get which type of help if they cannot change things by themselves. The general thrust is to inform choice not to dictate behaviour.

Particular types of problem drinking may require targeted approaches of the types that were so successful in, for example drink driving campaigns.

Advertising is a powerful tool and is used effectively by the drink industry. It is not the only tool available to health campaigners. Just as the drink industry uses product placement in popular TV programmes, public education campaigns can (and have) used

plot lines in soap operas to convey behaviour changing/awareness raising messages.

42. Given clear objectives, what is the evidence on the effectiveness of these approaches? What do they actually achieve? How can their effectiveness be measured?

This is a specialist area outside of the range of this author. My impression is that health education campaigns, on their own, are better at building knowledge levels than changing behaviour. Campaigns to change behaviour such as drink driving require back up (preferably local) publicity to make them effective. They also need regular repetition. To measure effectiveness, baseline data is required and this may or not be currently available.

As with many aspects of this national strategy the degree of joined up thinking required should not be under-estimated. A well thought through health campaign would be co-ordinated at a national and local level and followed up consistently over a protracted period of time. Reinforcing plot lines in soap operas with popular opinion-forming real or imaginary characters supporting a clear consistent message, might run in parallel. Media advocacy - the use of the media to highlight the extent of alcohol harm, in news programmes and documentaries - can be used to focus public attention on specific issues in support of prevention initiatives. But these risk being undermined if inconsistent messages about responsible drinking are accompanied by changes to recommended daily/weekly units (as they were in 1995); or, for example, the failure to support the European blood alcohol limit for drink driving; and the liberalisation of licensing laws.

43. How well is the sensible drinking message reaching its audience? Is it sufficiently clear? What is the evidence on its penetration and its effect on behaviour?

We need a clear message about safe drinking but a "sensible" message runs the risk of being perceived by the public as more interfering by a nanny state. Perhaps "responsible" drinking should be encouraged and "anti-social" drinking discouraged.

The clarity of the message recently has suffered from two impediments 1) Inconsistency 2) Complexity.

1) The Government's "Sensible drinking" report in 1995, which put forward daily rather than weekly drinking benchmarks has been widely criticised by a number of commentators (eg Duncan Raistrick and Griffith Edwards) and by the Royal Colleges of Psychiatrists, Physicians and General Practitioners.

2) Secondly the message about sensible drinking is fairly complicated and there is evidence that it is not readily understood by many health professionals (J.R. Kemm and C Rave: "Do people understand units of Alcohol?" Health Education Journal, 51:pp 59-63, 1993).

44. How well is scientific research feeding into alcohol education? Is the message based on sound, unbiased and uncontroversial research and are new findings effectively incorporated?

Prior to 1995, the Government's drinking message was set at a weekly intake of 21 units for men and 14 units for women, on the advice of the Royal Colleges of Psychiatrists, Physicians and General Practitioners. In 1995 the Royal Colleges revisited the evidence in the light of findings that small daily intakes of alcohol of 1-2 units may have a cardio-

protective effect, but found no reason to change their recommendations about sensible limits.

Changes were however made following an interdepartmental review in 1995. This was widely criticised by the Royal Colleges and others. The concept of "sound, unbiased and uncontroversial research" is attractive but not always available. In the aftermath of the CJD enquiry and Foot and Mouth epidemic, it seems that scientific research is suffering from its own public relations crisis.

45. Should particular groups be targeted for information and communication? Is there a need to provide more intensive alcohol education to groups other than young people (e.g. elderly drinkers)?

Age Concern have recently attracted attention to alcohol consumption in the twilight years.

Another group might be prisoners - perhaps the work of CARAT (Counselling Assessment Referral and Treatment) schemes could be extended to cover this area. Preconceptual couples may be worthwhile targets of educational materials, not just because of the link between alcohol use and reduced fertility in males, but because of the guidance to restrict drinking during pregnancy and breastfeeding for women.

46. What is the role of schools, colleges, universities and other educational institutions in providing alcohol education as well as support for alcohol-related problems? How can we best establish and preserve a healthy learning environment?

All educational establishments should have policies on alcohol use/misuse that treat alcohol in the context of a healthy lifestyle in a healthy learning environment. As stated elsewhere in this document, the use of knowledge about alcohol relies on the interpersonal skills to put that information to healthy effect and an attitude to risk avoidance consistent with responsible drinking. Self esteem and self efficacy are also important.

For people who do develop alcohol related problems, easy access to resources (including information about services) to help them cut down or stop drinking needs to be available in a form that is attractive and responsive to the sometimes seemingly separate counterculture that is the domain of youth.

47. What role is there for families/parents as role models or in educating their children on sensible levels of alcohol drinking and the risks of alcohol misuse? How can they best be informed and engaged in this effort?

Young people receive their earliest messages about alcohol from grandparents, parents/guardians, siblings and family friends. The type, amount, speed of drinking and reason for drinking provide a longstanding influence on appropriate/responsible and inappropriate/risky drinking.

Parents are not always aware that young people's first experiences of alcohol rely on access to their parent's supply of alcohol. Nor are parents always clear about what they should do when a young person in their charge returns in a very intoxicated state.

Alcohol Concern and (separately) the Portman Group have produced well designed leaflets to inform parents and young people about alcohol use. A strategy to equip parents and guardians with the knowledge and skills to talk about this issue will require a

range of materials, stimuli (cf question 42) and opportunities for further reinforcement.

48. What does experience show on the most effective means of getting messages across? Are there circumstances in which the Government is particularly well placed to do so, or conversely might be particularly unsuccessful?

Mass media campaigns are believed to be cost-effective because of their 'reach', ie the percentage of the target audience receiving the message. There is evidence that they can be successful if they seek to model specific behaviours rather than change attitudes (Barber, Bradshaw, Walsh: "Reducing alcohol consumption through television advertising", *Journal of Consulting, Consulting and Clinical Psychology*, 57, pp 613-618, 1989).

The lessons learnt in the drink driving advertisements are that targetting specific groups is effective especially when viable alternatives (named non-drinking drivers) are offered and offenders are portrayed as antisocial. But it is important to remember that the police themselves provide the embodiment of the deterrent in every patrol car. This is followed up in the new year by figures revealing the number of positive breathalysed drivers. It is notable that the figures for the summer campaign received less publicity.

49. What can we learn from educational initiatives in the field of illegal drugs?

Education messages need to be credible, honest and clear. School policies aimed at responding to drug related problems need to be adopted by all schools. Parents need to be involved in education initiatives. Awareness and information on their own are not as effective as knowledge and personal skills training. Quality assurance in education has not been applied to drugs education in the same way that it has to drugs treatment.

50. Do you have views on the existing regulation of advertising on alcohol?

The drinks industry argues that advertising does not increase total demand for alcohol; it simply defends market share. Advertising is aimed at adults and considerable care goes into the design and delivery of adverts in an attempt to associate positive social images such as humour, sociability and sophistication with the product.

This manipulation is likely to leave a particular impact on younger adolescents who often seek adult status. It is likely therefore that such advertising promotes alcohol use, reinforces underage drinking, recruits young people as new drinkers or leads them to experiment earlier than they might do otherwise.

Consideration should be given to reviewing the times at which advertisements for alcoholic drinks can be screened on television (eg observing the 9pm watershed); removal of all cinema alcohol advertising other than for age 18+ certificated films; restriction on billboard advertising near schools (similar to tobacco adverts); and restriction of alcohol related sponsorship.

The shape of the market and market-based solutions

The drinks industry is a major part of the national economy. It provides large numbers of jobs both in supply and distribution; it influences trends and fashion through its advertising; and it provides a substantial portion of tax revenues. Understanding how that

market works, what drives it and how it responds to demand is essential to producing an effective strategy.

Questions

51. Do you have any thoughts on the likely evolution of the alcohol industry over the next decade?

Possible trends may be:

- increasing early socialisation of the very young (infants) into pubs using family friendly facilities such as playbarns/happy eater restaurants.
- targeting the teenage/youth market with alcohol-free entertainment/venues to cultivate brand loyalty and exploit a lucrative gap in the market.
- designer alcohol drinks that purport to make you healthy/enhance your intelligence/supply vital nutrients/fight disease/mend your genes.
- cheaper but still very profitable non-alcoholic drinks
- sharper distinction between themed pubs: Gryffindor and Slytherin and Mufflebuff and Ravenclaw; not simply Hogwarts.

52. What is the relationship between the creation of trends and fashions in alcohol consumption by the market and consumers responding to trends and fashions? Are there discernible patterns which the Government might use in responding to the effects of alcohol misuse? Is there useful evidence we might draw on?

It is likely that successful marketing draws upon and accentuates something already available in the culture of the target audience. It is widely believed that the youth targetted strong ciders "K" and "Ice" have their namesakes in rave/dance-scene drugs Ketamine and Methamphetamine respectively.

The cult of personality is equally strong. Arsene Wenger's comments about avoiding alcohol are said to be hugely influential in making your people think twice about their drinking and fitness.

53. How far do you foresee research and development creating innovative market-led solutions to the problems of alcohol misuse?

It would be interesting to see if the same type of legal action/class action that is currently being taken against tobacco manufacturers is repeated by damaged drinkers against the brewers and distillers.

One might equally fantasise about a product that neutralised the alcohol in the blood stream when it reached a concentration around the same level as the drink driving law.

54. How best can Government work with the alcohol industry to reach consumers? What approaches have been shown to be effective in England, the devolved administrations and further afield?

Is it unreasonable to suggest that Government might choose not to work with the alcohol industry? Are the interests of Government and the industry not competing rather too much already? What is the level and magnitude of influence of the alcohol industry on the Government? How does the Government reconcile loss of excise revenue with increased health and longevity? Might it not be helpful to fully understand the links that

already exist and then decide which should be increased?

55. Are there other commercial interests which can influence drinking behaviour?

The home brew market is often forgotten, and the degree to which bootlegging takes place is often raised by local crime and disorder partnerships. Sports sponsorship is an antagonistic influence.

The economic costs and benefits of alcohol

Alcohol has significant costs for the economy. It costs the NHS and the police. It costs business money because of lost productivity and in some cases the need to repair alcohol-related damage. And it can be expensive for individuals who drink heavily and may find themselves unable to hold down a job. But it also has benefits. It brings in tax revenue and contributes to GDP. And it contributes to personal and social wellbeing for many. Part of the work on the project will be to form a clear picture of these costs and benefits.

Questions

56. How clear is the evidence both for the wider economic costs and benefits of alcohol? Are there key pieces of research of which we should be aware?

Please see the response to question 15.

57. Where are the gaps in the available data on the economic costs and benefits of alcohol? Are there any obvious limitations we should be aware of? Are there any particularly helpful methods for assessing costs and benefits we should be aware of?

The home brew market is not well researched; and imports of duty free alcoholic drinks.

58. What principles could guide us in deciding who is responsible for costs? How far should they fall to individuals, how far to business and how far to Government?

It is probably too simplistic to apply a 'polluter pays' principle to this problem; however there is an appealing circularity of a hypothecated tax on alcohol to pay for prevention and treatment.

Equally it must be remembered that if the price of alcoholic drinks becomes too high consumers turn to illicit imports and home brew. Consequently tax returns decreased and the Chancellor's facility to fund treatment is reduced.

59. What are the economic benefits of having an alcohol industry? Can we easily quantify them?

The author is not in a position to answer this question; the response to question 15 addresses this in part.

60. Alcohol misuse can increase absenteeism and decrease productivity, whilst moderate consumption of alcohol may be beneficial in terms of reducing stress and tension and facilitating networking in the workplace. What in your view are the links between alcohol use and educational and occupational attainment?

The author is not in a position to respond to this question.

61. Are there particularly effective workplace-based initiatives designed to tackle alcohol misuse that we should be aware of?

The federation of Workplace Alcohol Services may be able to advise on this issue.

How to respond

You can send comments to:

SU/DoH Consultation
Room 4.6
Admiralty Arch
The Mall
London SW1A 2WH
E-mail: su-dohconsultation@cabinet-office.x.gsi.gov.uk

It would be helpful to receive comments by e-mail where possible.

The deadline for responses is 15 January 2003.

Further copies of this document can be ordered from:

Department of Health Publications
PO Box 787
London SE1 6XH

Telephone: 08701 555 455
Fax: 01623 724 524
E-mail: doh@prolog.uk.com

This document is also available in electronic format at:
<http://www.strategy.gov.uk/2002/alcohol/consultationdoc.shtml>
<http://www.doh.gov.uk/alcohol/alcoholstrategy.htm>

What happens next?

This consultation exercise will run until 15 January. This document will form the centrepiece of a conference to be held in London on 22 October, and will be supported by three regional events during November. The responses will inform the development of a Strategy Unit interim analysis paper, which will be posted on the Unit's website early in 2003 and will form the basis of developing policy options and producing the final report. You can keep in touch with this work by visiting <http://www.strategy.gov.uk/2002/alcohol/main.shtml>. We cannot reply personally to every submission, but would be grateful for contact details so that we can contact senders if we need clarification of points or further information.

If you have any comments about the consultation process please contact Paul Greening.

paul.greening@cabinet-office.x.gsi.gov.uk

Paul Greening
Cabinet Office
Head of Consultation Policy Team
Strategy Unit
Room 1.30
Admiralty Arch
The Mall
London SW1A 2WH