

Replied via email 30/1/03.

'Tackling social disadvantage & health inequalities through diversity and effective partnerships.'



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8th January 2003

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Dear Strategy Unit

Re: Alcohol Strategy Consultation Exercise

Attached please find the response from this agency which has been simply presented by using paragraphs numbered in accordance with the questions raised in the consultation document.

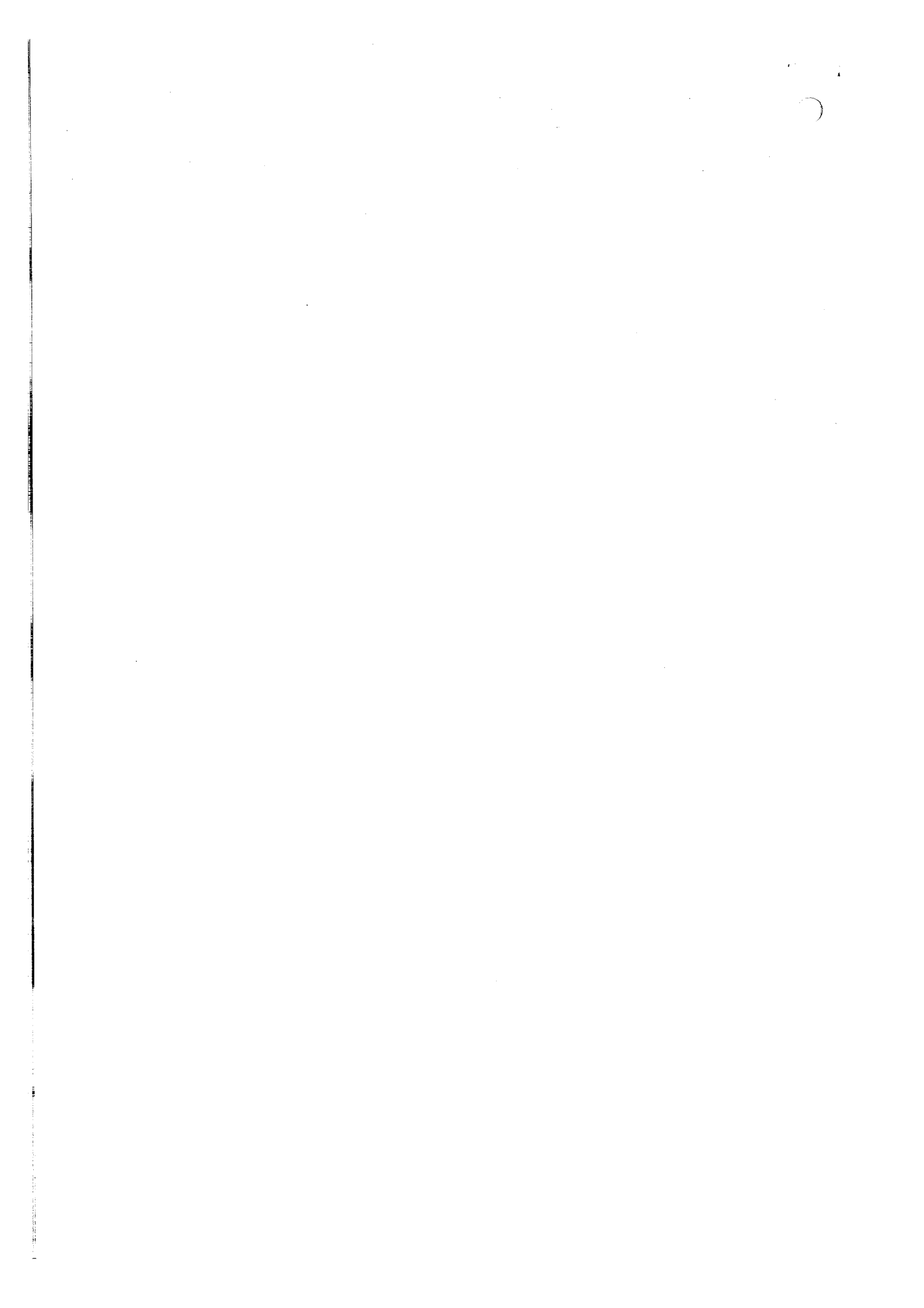
For my sins I have found myself writing the response also for Coventry DAT, and I believe that Warwickshire will be using some of this material. However they are not the same, and I recommend this one to you as having the most relevant material about good alcohol service practice. We have quoted several pieces of very contemporary work, already working to Models of Care Standards, Assessment and Care Management systems, etc. and would be pleased to share that material further, or to undertake any action research that might arise. We are quite a large agency, operating through Coventry, Warwickshire and now Birmingham with now over 100 staff, and are yet small enough to have some truly excellent managers who keep services very much in sharp focus.

Please feel free to come back to us, and thank you for the excellent manner in which this consultation exercise has been conducted.

Yours sincerely

Geoffrey Cobbe
Chief Executive

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The Swanswell Charitable Trust

National Alcohol Strategy Consultation Exercise

Introduction

Thank you for enabling Katie Law's extremely clear and competent contribution to our recent conference in Rugby that spent a day looking at the implications of the strategy in the context of our history of relatively well funded, evidence based services operating as the lead agency for community alcohol provision in both Coventry and Warwickshire.

The following represents the view of the Swanswell Trust, a 'not-for-profit' agency providing very contemporary Community Alcohol Services throughout Coventry and Warwickshire, as well as a major Primary Care and Criminal Justice Drug service in Birmingham. The Swanswell Trust welcomes the publication of the consultation document, and the approach implied in the questions raised. Our views are informed in part by the local history of having well developed, modern alcohol services providing services in Tiers 2,3,and 4(Residential rehab access), largely located in Primary Care settings that have established comprehensive community services , using modern models of intervention. However it may help the reader in putting our response into context to make some broad but, we consider, very relevant points:-

i) Funding

It is very obviously true that the implementation of the National Drug Strategy has benefited enormously from both specific funding and the influence of both DPAS and the NTA. We realise that the level of funding allocated for drug service development will not be repeated for Alcohol Strategy implementation, but without some financial contribution and incentive, progress – whatever the merits of the Strategy – will be much less than needed to make a serious and measurable impact at locality level.

ii) Funding Anomalies

The recent NHS reforms are generally welcomed by this organisation, but already we see the Unintended consequences of new commissioners, previously entirely unconnected with Alcohol services both unable to comprehend the complexity of services and their funding, and Being unable to afford the issue of even maintaining existing services the attention required. However the potentially most serious issue arising all across the country is that some Primary Care Trusts are both **providers and commissioners of alcohol services, and have a Potentially serious conflict of interest, with an inherent potential for purchasing their Own service, rather than encouraging competition and using market forces to drive up Quality. This is later addressed, but it will be very difficult to withstand challenge that Commissioning in this process is both fair and objective.**

iii) Overview

While there has been a view from some sectors of drug services that the presence of both DPAS and the NTA has made heavy demands on local services, we certainly do not share that view. Both organisations have obviously held DAT's to account, but have done so in a manner that encourages best practice and have facilitated very valuable progress. If there is to be a National Alcohol Strategy, we hope that its implementation will come within the terms of a similar process to achieve the best result within the terms of available resources. Even without new resources, this external influence could achieve improvements and consistency within the existing resource base. New money is not the only issue. There however may be a question to answer at some point in terms of whether there may be benefits from merging DPAS and the NTA to integrate their work and perhaps achieve some economies of scale.

iv) Minority Needs

While both the tone and content of the consultation paper is generally very welcome, it is surprising that the question of ethnic minority needs are only briefly considered. While there have been a number of specific initiatives to address needs of specific groups (**we have two reasonably successful schemes in Coventry with both Asian and Irish communities**), it is unlikely that any such community would express the view that they were usually sufficiently consulted or that their particular needs were

adequately understood or addressed. The reasons for this deficit are numerous, but include funding limitations, **recruitment difficulties (although again these have been very successfully addressed in the Swanswell Community Alcohol Service in Coventry and may offer a model of effective practice)** and especially the variations in patterns of consumption between generations which create a complex pattern of need within those communities. A very important opportunity will have been missed if this complex matter is not addressed in the final strategy, if only to establish properly funded pilot schemes from which good practice can eventually be developed at an appropriate national standard.

vi) Media and Sponsorship

A wider issue, but one that can hardly be ignored, is the manner in which the media – but especially television, uses alcohol consumption on an obviously frequent and arguably irresponsible level, as an almost natural background to typical behaviour and social relationships. Popular ‘soaps’ give the most obvious example, but so does sport with the paradoxical link between alcohol related drinks and the highly athletic performance of sportspeople and the clubs that they represent. This is a difficult issue to address, and the prospect of Government ‘interference’ in a free market or censored media productions would be strongly resisted. However so was the question of tobacco sponsorship, and the health and social consequences of alcohol related problems can surely be argued to be in part the responsibility of the international organisations that profit so much from sales. Increased and specific taxation on alcohol advertising (which would then perhaps affect companies sponsoring media productions) may at least be worthy of consideration.

vii) Advertising

This is mentioned in greater detail later, but the freedom of advertisers and the alcohol industry to advertise their products in a manner that conveys social and intimate success illustrates just how cynically younger people are targeted. Currently a major producer of a whisky based product uses the picture of disinhibition and risk taking among young women drinking the high alcohol product, also presented as a mark of sophistication. If we really want to reduce alcohol related risks, there is surely a strong case for limiting or taxing heavily any alcohol related advertising. It will be very perverse indeed to have a National Harm Reduction Strategy and for commercial interests to be advertising, in effect, to contradict its purpose.

viii) Recommended levels of consumption

These and the issues that follow are not in any way conveyed as a prohibitionist approach, but simply one that seeks to reduce the harms associated with higher and seriously damaging consequences of alcohol consumption. The proposals that follow are largely focussed on the ‘heavy’ drinker, for whom the prospect of 14 or 21 units per week is simply unattainable. Indeed there is a question for this policy to address in considering recommended levels. The evidence base for the current recommended levels is very questionable, and probably does little to persuade problem drinkers to take the issue seriously. If we are to have target levels at all, it would be worth considering the Australian figures of 21 and 28 units per week which are more credible from a consumer perspective.

.....

The following remarks relate to the corresponding paragraph in the consultation paper. Where any paragraph is omitted, it can be assumed by the reader that we have no particular point to make, or that we consider that others may be better placed to make a helpful response.

Principles

1. The purpose of any social policy is surely to bring a sense of order to society that is understood and usually welcomed by the ordinary and reasonable member of the community. In our experience people generally enjoy the sensible use of alcohol, but are very troubled when it causes harm to individuals,(whether as drinkers or affected others) or to communities. The points for intervention that would fit well with this approach would be:-
 - In educating the general public to understand safety and sensible drinking – as has been so previously successfully achieved in the question of drink impaired driving.
 - In having controls placed on unacceptable behaviours, with suitable remedies including both punishment and/or therapy.
 - Systems in key settings –primary care, A&E, acute hospitals, police stations, etc. to identify people at potential risk and screen for levels of alcohol consumed, leading to appropriate

intervention. **We can furnish you with very convincing data from our own secondary care training and screening system that enables health professionals to identify acute general hospital patients who are attending through alcohol related causation, and who are then referred out with a clear care pathway to our primary care alcohol service that deals with them in the community, often at a point when due to health, domestic, employment or other legal concerns they are very motivated to accept help.**

2. Individual responsibility is arguably properly limited when individuals' behaviour and/or consequences have a potentially or actual serious adverse effect for self or others. The extent of the limit needs to be in proportion to both the effect of the adverse consequence and cause. Those identified in general health settings would need to be screened and given appropriate advice – almost a Tier 1 intervention. Those behaving at a seriously affected level whether in society or employment require a well reasoned and balanced response which may involve some level of coercion as a condition of retaining employment or freedom. Numerous examples already exist which demonstrate that such systems do have very good outcomes – Drink Impaired Driver Schemes, Offending and Alcohol Programmes, Workplace Alcohol Policies, Primary Care Alcohol Services, etc. **Again we can provide convincing evidence of schemes operating in each of these fields and in which we have measurable indicators of effectiveness. Tel Chris Robinson 024 76 226619.**
3. Sensible screening and assessment, linked with appropriate treatment interventions and/or the judicial system – Arrest Referral Schemes are a very good example but are less well developed in alcohol related offending than in drug misuse/offending. Alcohol related Domestic Violence would also benefit from this linkage. Why cannot existing drug arrest referral schemes be adapted to address alcohol as well with a rapid treatment path to the local Community Alcohol Service? This would facilitate a response to people with serious levels of need at little if any additional cost.
4. Answers to this question are almost philosophical and could be debated perhaps indefinitely. However we do know from the evidence that many **consumers** are eager to influence the design and delivery of services and this agency both applies and strongly supports that concept. The question of the role of **voluntary/not for profit organisations** is also important. We know that service users have a resistance to statutory services and express an appreciation of opportunity to be treated in the voluntary sector. However we take the view that there is no automatic entitlement for any statutory or voluntary agency to be a service provider, and that the issue should rest on clear and objective measures of efficiency, effectiveness and cost, using sensible and objective standards. Models of Care, QuADS, NTA performance indicators for drug services etc.. now provide the clarity that contractual frameworks require. **There is however a serious and probably unintended anomaly, mentioned in the introduction above but emphasised again without apology now in NHS commissioning arrangements, in that some Primary Care Trusts are themselves both providers and commissioners of alcohol (and other) services. It may be difficult both to demonstrate and convince both other providers or consumers that commissioning in these arrangements is both fair and objective.** The responsibilities of the commercial sector may be difficult to address in legislative terms. However there is clear evidence that steps to ascertain age, creating safer drinking environments (shatterproof glasses, not selling in bottles in pubs/clubs) have very direct benefits. Anecdotal evidence suggests that rural pubs take a very light view of their responsibilities in selling to drivers, on whom their trade may increasingly depend. It is almost unheard of that a publican is involved in charges associated with the drink driving of a customer. Clearly the balance between responsibility and profit is at the core of this, and we know how reluctant the drinks industry is to tackle this in a meaningful manner.
5. The principles of a national harm reduction strategy may be many and varied. However a fundamental objective or principle must surely be that it must be **cost effective and evidence based at the point of implementation**, the tools to do this are easily available – the Christo inventory being a reasonable starting point. However if the success of the National Drugs Strategy is used as a model, that evidence shows that **there is a direct correlation between investment, monitoring and results. In other words, a strategy will be much less effective unless it comes with at least some funding, and will benefit from the influence of a reliable expert body such as the NTA/DPAS – mentioned elsewhere.**

6. Defining alcohol misuse is always difficult, and the use of 14 and 21 units does not help very much in this respect. The most helpful description is that frequently used in both commissioning and operational service provision, which is **'Alcohol misuse arises when individuals put at significant risk their own health and/or safety, or that of others, including communities, whether or not offences are committed as a result.'**
7.
 - a) Those who are putting their own health at moderate to significant risk
 - b) Those who are putting their own safety or that of others at significant risk
 - c) Those who as a result of alcohol misuse, use a disproportionate level of public funds, for example from the NHS or Criminal Justice System
8. There will be numerous views on the question of trends in drinking and wider social change. However it is strongly believed, as mentioned elsewhere in this paper, that television has done much to 'normalise' heavy drinking, and that the link between sports sponsorship and increased consumption is very real. If it was not, surely the alcohol industry would not be investing so much in it. Advertising drinks to attract younger customers is also an area where the cause and effect is very difficult to dispute and raises again the question as to whether **alcohol related advertising should be taxed or banned.**
9. Target groups in some senses define themselves by their illness, injuries and criminality, or by being seriously affected by such. However women are generally disproportionately under-represented in their attendance at services, as are members of so called ethnic minority communities. In Warwickshire and Coventry we are advised by credible members of such communities that very high alcohol consumption is now occurring in Sikh communities, and increasingly in younger Muslim groups. However further anecdotal evidence seriously suggests that refugees are also at increasing risk, yet for all of these groups, services remain under informed and under developed. Well organised action based research may be an important feature of the new strategy, in order that direction can be given to the development of provision for such groups.
10. It is simply not going to be the case that our society will be without an alcohol industry, nor would that be desirable. However there would be in the extreme case of its removal, a major loss in the social fabric of families and communities for whom it is an important and responsibly undertaken leisure facility, decline in aspects of both urban and rural life, especially if public houses and clubs became less or non-viable, and serious loss of employment in the brewing, transportation and retail trades.
11. There is no clear and recognisable drinking culture in this country. Differences exist between social classes, cultural groups, ages, gender. Etc The issue is surely that services need to be commissioned to deal with local needs/priorities, based upon a well informed assessment of those needs, preferably in the context of a nationally applied framework, as in the National Drugs Strategy.
12. Behaviour is affected by multiple influences – all of which are noted in the consultation paper. It is clear that marketing influences behaviour – otherwise it would not be used, as does price. Consumption is usually higher in major public house chains that reduce costs in quiet periods – the 'Weatherspoon model' - which is very successful – at least from a marketing perspective, and 'happy hours' and 'daisy chains' are designed to make publicans profits greater!! We are unable however to judge whether such factors could be used in reverse to improve behaviour, it is probably unlikely. Restrictions on marketing may be an important contribution, but marketing controls are almost impossible with the level of cross channel imports now taking place, and often being sold in areas of deprivation, as convictions in Coventry illustrate However the issue may be that the focus ultimately needs to be on the important minority who get into difficulty and need to be identified early – at police stations, A&E, General Practices, Courts. Appearing in such settings is demonstrative that harm is actually occurring, and those involved may – when faced with immediate consequences – be motivated to consider change. Evidence does support that fact.
13. Anecdotal evidence, and comment from consumers, is that risk is frequently dismissed, until events begin to move out of control. Most people know they are drinking too much, but know of others who they believe have drank more without coming to harm. The formality of police

involvement or a serious health risk does usually motivate for change. The evidence of punishment and social stigma associated with drink driving has also been a very valuable tool in changing patterns of behaviour – drink driving being the most obvious example.

14. The question of 'sensible limits' is very vexed. The research that was used to set these figures is very questionable – the graphs only 'blipped' very slightly at 14 and 21 units, and thereafter flattened out to rise again after more than double those amounts. It is reported by service providers that the recommended limit levels actually impede their work, and that they could work better without them. Whereas reducing to 14 an 21 units can be unattainable for many who are drinking at very high levels, reducing to 30 – 35 units is a realistic and for them very beneficial improvement. If units are to be used in the new strategy, it may be much more realistic to adopt the Australian figures of 21 and 28. **It is however very important to think before setting any recommended levels as to how such figures will be used. It is assumed that a new strategy will have at least some association with targets, and it is strongly recommended that any measures of improvement or health gain are based on an alternative formula because the current figures, as earlier emphasised, are unlikely to be helpful in demonstrating effectiveness of what may otherwise be a very helpful strategy.**
15. This is very much the business of Health Economists, and we suggest that the Strategy Unit refers to Christine Godfrey of York University who is very skilled and knowledgeable in this area of research. However we know that health consequences include injuries, especially head injuries, and extreme cases can lead to alcohol poisoning with coma and/or death. The serious health consequences of alcohol misuse are very well established – liver, peripheral nerves, cerebellum, muscle, central nervous system, digestive system, etc. Consequences are not only related to volume consumed, but patterns of consumption, hence the necessity to address 'binge' drinking.
16. The excellent alcohol services in both Warwickshire and Coventry Community Alcohol Service, both of which benefit from very well informed commissioning, can demonstrate the major cost improvement and effectiveness of a community as opposed to inpatient model of care, including community detox, stabilisation and maintenance. It can also demonstrate the benefit and impact of establishing effective alcohol screening in secondary acute care hospital settings, intended to avoid repeat alcohol related admissions. Again this is an area where other research will assist – Christine Godfrey being again the obvious example. However Douglas Cameron's work in Leicestershire demonstrated how much the presence of an effective Community Alcohol Team was in reducing a wide range of health related costs – especially alcohol related illness and mortality levels usually treated in acute NHS settings. While the incidence of psychiatric admissions was virtually unchanged, the value of and effect of the C.A.T. on major acute hospital provision was very marked indeed. He is available on 01455 – 290123 and always very willing to assist in serious exercises such as this.
17. This paragraph raises two separate issues. We suggest that the question of prevention of dependence/ misuse is covered elsewhere in this response. The question of professional competence is of major importance. Almost no training on the identification and effect of alcohol related health and social problems is provided to community nurses, social workers, probation officers, youth workers and even general practitioners, all of whom should be expected to provide at least 'Tier 1' services. This has wider and very serious implications such as failure to identify alcohol as a factor in child protection work/neglect. A meaningful and consistently applied/reapplied strategy at local level, perhaps also embracing drug issues is probably the most obvious way to address this on a systematic basis if the 'Tier 1' concept is to remain the foundation of the pyramid of services, as surely it must.
18. It is assumed that you have access to Christine Saunders' work which offers effective and economic approaches to treatment modalities. However our local experience, widely shared with providers and commissioners in other localities, is that 'brief interventions' if well and clearly provided are effective if applied to the right audience, and that **solution focussed and cognitive approaches** are particularly effective if applied in conjunction with a full and clear **assessment(including risk assessment) of need**. However this is not a very clearly researched area, and definitions of what, for example, a brief intervention is vary from service to service. A national policy would benefit from some clear definitions to bring clarity in the use of language and policy/practice development. Again the evidence demonstrates that timely identification of need is

an important consideration, and we can provide evidence from the contrasts of the mixed environment of both very rural and very urban towns of Warwickshire, and the city of Coventry of the benefit of applying this approach in both primary and secondary care settings. The Swanswell Trust service uses the Christo Inventory to evaluate risks and progress, and would be pleased to share their results with you. This approach, while using traditional counselling methods very selectively, is almost entirely based on solution focussed and cognitive approaches, but only after full assessment of need. **Our view and evidence is very clear – even long term drinkers can be motivated to respond by effective engagement, and that multi dimensional changes are most certainly achievable for most clients. The new strategy would however do well to remind commissioners that alcohol impacts on every Health Improvement Programme, and usually to serious levels. It is also the major cause of disruption and waiting times in the controversial area of A&E. Its effect is therefore multi dimensional both within and upon the NHS, and has a direct effect on the political issue of access to hospital services generally, and A&E in particular.**

19. Yes, some do and very effectively – as noted in paras 16 and 18 above. However the absence of knowledge in this area is not confined to Tier 1 type services, but is very evidently missing in several lead agencies and commissioning systems and there is certainly a need to create guidance not only to assist commissioners generally, but to establish a reasonable level of consistency in service provision and philosophy across the country. This does not detract from the importance of responding to local needs, but does establish standards as applied to other elements of health and social provision.
20. Surely the most important lesson from drug service provision is that until we had a national strategy, but more importantly until the NTA was established to ensure that services moved and developed in accordance with the strategy, progress was very patchy and inconsistent. We firmly believe that this strategy will only benefit from bringing alcohol services under the same or a similar umbrella.
21. Safer drinking environments, trained bar/door staff, penalties for landlords/proprietors who do not take the issue seriously, arrest referral schemes for alcohol users, effective screening in A&E departments to identify and tackle frequent recidivist alcohol behaviours. Many are very frequent re-offenders.
22. Links between mental health problems and alcohol are very well demonstrated - especially in suicidal behaviours. This does not need any radical approach to resolve, but well defined care pathways, well trained staff and effective partnership working with well defined roles and responsibilities. The model established between the Coventry Caludon Mental Health Unit and the Coventry Community Alcohol Service offers a very good model of practice. (Contact Christine Robinson, 024 76 226619 for material/information).
23. Very well documented by Alcohol Concern. See 'Britain's Ruin' as a recent example.
24. Yes – violence including domestic violence, drink driving, theft, occasional arson, some linkage with sexual offending. Little evidence of one-off offending – although drink drivers are calculated on basis of convictions, they usually admit frequent similar behaviours prior to arrest, as is the case in domestic violence.
25. Evidence is very convincing, but is often offered as an excuse. However incidents of violence almost always involve the clear judgement by the perpetrator that the victim is less capable. Even those who are seriously drink impaired do not 'pick on' weaker people. There is enough direct linkage between high consumption and offending to both fuel public perception and to justify it - e.g. football violence fuelled by alcohol, fights at closing time, night club incidents, drunkenness and attendance at A&E.
26. No single solution, but calls for a multi agency task group to work to reduce alcohol related crime and to achieve the highest possible effect from co-ordinated partnership working. Cause and solutions will vary from one locality to another. The mechanism is certainly a policy requirement, but the solution will be locally determined.

27. Anecdotal evidence is clear. While alcohol is associated with the entertainment industries of urban life, pubs and alcohol are increasingly becoming the main attractions for younger people in rural localities, as they often are for other generations. The problems for rural communities have parallels with urban problems, and can be similarly disruptive, but with the added problem of lack of public transport and risks of drink driving, especially in poorly policed areas. Key issues about publican responsibilities.
28. Leicestershire's Community Alcohol Team has employed a worker to deal with safer drinking environments with reported good results. However there is now clear research evidence of the value of safer drinking glasses in reducing injuries, and as mentioned elsewhere, surely a similar case for prohibiting drinking from glass bottles which have a high potential for permanent harm in violent incidents. This would be a simple matter to address and would have a high level of public support. Most adults know of somebody who has been 'glassed' and would welcome steps to prevent further similar offences.
29. It is sadly but undeniably a fact that multi agency working is not a natural or easy phenomena and frequently lacks the deliberate efforts needed to make it work well to achieve solutions. Variability in funding of provider organisations can lead to competition rather than co-operation at both a strategic and operational level. Measures are required to bring to partnership working generally the measure of sophistication that will produce harmonised results. The presence of well informed commissioners and/or the NTA or similar to bring a strong focus at both commissioner and provider level may be the most effective solution. **It is very unlikely that services will engage well with consumers until they can engage well with each other, and this makes the case for principled and agreed partnership standards all the more compelling.**
30. No, it is not correct that that anti crime and anti social behaviour initiatives should only be targeted on the young. There is certainly a need for that, but suitable measures are still selectively needed for older groups. However the definition of 'young' needs consideration. Does it mean over 12 yrs?, under 18 yrs.?, under 21 yrs.?, under 25 yrs.?. The better systems for intervention involve building in specific service attributes that relate to the needs of service users – consent to treatment and confidentiality policies especially when dealing with those of especially under 18 yrs.
31. This is a very interesting aspiration which may benefit from more research. The answer is probably yes, but it may be very difficult to engage audiences to achieve their co-operation. Given that one third of the day is usually spent in work or education, a significant proportion is spent asleep, there is little time or opportunity left to change patterns of behaviour with alcohol consumption and effects.
32. No Drinking Zones – well researched by Graham Fanti (we have copies of his work if it is required) – show that such zones only work effectively if combined with a pattern of services that offer engagement with the drinker. Simply creating No Drinking Zones in town centres – often in the interests of promoting tourism or commerce usually move the problem out to other areas where the impact is similarly offensive but more dispersed. The issue is much less about powers and policies than it is about having an integrated and well targeted approach to tackle serious levels of deprivation and social exclusion at locality level.
33. Yes if consistently policed and applied. There is a parallel in the question of noise abatement and public nuisance. Legislation exists, but is cumbersome to apply, and expensive to 'police'. There is very probably a high level of public support for reducing the threshold for prosecution, but for it to gain public confidence would need to be seen to be adequately policed and effectively applied.
34. Drink drive policies only work if they are both enforced and seen to be enforced. That they have is a very successful feature of this country's legislative framework. The lesson is surely that court disposals do need to be linked to access to effective treatments to prevent the unacceptable levels of re-offending, even in drink driving. We provide a radical Drink Impaired Driver pilot project in both Coventry and Warwickshire and are the only vol. org. in the U.K. so doing, funded by the National Probation Service which is making very clear and measurable progress in this field, and which may offer lessons to apply to other groups.

35. Domestic violence and alcohol misuse have very worrying and important association. A simple and cost effective solution could be based on a protocol between the Police service and the local Community Alcohol Service to fast track referrals from the Police Force after they had been called to domestic violence incidents where alcohol was judged to be a factor. This could be applied in conjunction with charges/arrest, as an agreed alternative, or as a single solution. Victims too need to be advised of where to gain access to services. Most alcohol services provide for those affected adversely 'by somebody else's drinking'. **The national strategy would do well to give this matter a prominent focus because not only are patterns of response across the country very inconsistent and therefore harm to victims may be higher than it needs to be, but the risk to children is very high, and would benefit from being specifically addressed in local child protection systems. Excellent opportunity for inexpensive action research.**
36. Locally evidence, not surprisingly, demonstrates that young people who are socially excluded, having lower educational attainment/school exclusion histories, and/or subsequent employment difficulties are at greater risk of personal health risks or injury, as they frequently are in the case of other elements of social malaise. However Area Child Protection Committees are now beginning to attribute increases in registration of children at risk as being alcohol and/or drug related, and therefore in a context of services that put child safety as a paramount consideration, younger children affected by parent/carer alcohol misuse are a source of very serious concern.
- 37/
40. Youth Offenders are clearly associated with both alcohol and drug misuse, but may benefit from having the strength of the leverage from the terms of sentencing to hold them into treatment systems. Coventry Youth Offending Service has developed a very effective scheme with the Swanswell Trust's younger peoples' alcohol and drug service – CADDY – meaning Crime, Alcohol, Drugs, Disaffection and Younger People – that has tackled successfully both alcohol and drug misuse and related offending. Our experience is that good and clear partnership working is the key to achieving necessary outcomes and results, with each component of such partnerships understanding both their own and everybody else's responsibility in the process. The local view was that this service needed to be placed with a non mainstream service (although both Alcohol and Drug services do undertake main stream activities that would otherwise be conducted by mainstream/statutory services) and this has worked with good results.
- 41/
42. The questions raised concerning health education/promotion are clearly relevant, and the theory that educated individuals behave more responsibly should apply. However that may not apply as convincingly as health educationalists may prefer, and some in the field believe that the credibility of the health education approach is lost because recommended consumption levels are so low. Some simple measures could be easily adopted – unit measures printed on bottles, cans, beer mats, pump clips, lager taps – people do seem genuinely puzzled about the strength of drinks – the 2 unit per pint concept being the most frequent misconception now that typical strengths are in the order of 4.6 to 5.2% per pint, which is at least 3 units per pint. The 'North East' alcohol education scheme in the early 1970's achieved a very wide improvement in the knowledge of the public about harmful effects of alcohol, but did not have any measurable effect on levels of consumption. People were reported to drink the same amounts generally, but to worry more about it. There may be value in looking at new models of health education and whether or not any international evidence may assist. **However unanswered questions should not detract from the fact that we need a strategy to direct help to those who have already and/or who will almost always ignore a sensible drinking message, and who can be identified with relative ease in medical and criminal justice settings.**
- The area that would benefit from inclusion in the strategy is that of workplace alcohol policies and teaching of the workforce because of the direct potential effect on industrial accidents, job security, company performance, effects of unreliable or absent colleagues on their peers. The context of employment linked education programmes may have a greater impact, and the evidence from workplace alcohol policy development is that it does work, not only in improving the health and performance of the target audience, but in increasing efficiency of business generally.**
48. There is no accurate basis upon which this question can be answered easily. It is difficult to judge where the message should best come from, and again the answer most probably lies in several areas, as long as there is consistency. Government messages and campaigns, limiting

sponsorship, modifying advertising, consistent messages in schools, steps within the alcohol industry – (most people seem to believe what they are told in their pub!!) but there is an inherent problem in the field of health promotion nationally. So often it is provided entirely separately from operational services, and offers messages that do not reinforce local commissioning and treatment strategies. This therefore leads to the question of how clear is a local alcohol strategy, and what should be its priorities. Do health promotion schemes actually work with alcohol consumption when the evidence seems to suggest that impact on actual behaviours across the population generally is poor. Again opportunity for research to ensure that investment in this expensive service area yields an appropriate result.

49. It is difficult to judge what can actually and accurately be learned from advertising in the field of drugs misuse. Perhaps a more effective model may be that associated with HIV/AIDS which despite its critics certainly made a significant impact, lost perhaps because momentum was not maintained by both investment and creativity. The increase in HIV infection correlates very clearly with the point at which Government investment in this major health concern reduced.
50. Advertising of alcohol is considered strongly by those working in the field to impact upon behaviours. As noted above, if it did not work, the industry would not invest in it. The case is often made that all advertising does is to move the customer from one product to another, and that consumption is not affected. However we now see major international brands producing numerous beers, lagers and designer drinks, and advertising each of those products separately and in competition with their own brands. They would not be advertising to move the customer from one of their products to another and are having their desired effect of increasing consumption, especially among the young to whom advertising is cynically targeted.
51. If current trends continue, the indications are that the alcohol industry will largely become concentrated among major monopoly companies with huge advertising and sponsorship power, just as has occurred already especially in the USA. However whatever does develop, and no matter what systems are applied to limit consumption, we know that we will always face alcohol problems in society just as occurred during the prohibition era of the USA, and just as now occurs in Sweden even with very high cost penalties and extremely serious punishments for even small levels of alcohol when driving. The need for an immediate National Alcohol Strategy does not need to be impeded because we do not yet know how the industry will evolve in the next decade or two.
- 52/54. The need for solutions is clear, but much easier than implied. We know what does work, we know what it costs, we know that as yet it is not a national priority and is not funded. At local level it is impossible with current funding to spend more on these services when there are so many other competing health and social care requirements that attract popular appeal among the general population, and much more than alcohol service development would with the general population. Drug service investment is similarly a politically contentious issue, but the links between drug issues and crime are easier to demonstrate than the similar and chronic consequences of alcohol misuse. Little beyond a simple service framework preferably based on that of the national Drugs Strategy, applied with the competence demonstrated by DPAS and the NTA, and given a moderate level of at least medium term funding is required to make a measurable difference, as the evidence of Douglas Cameron's earlier work demonstrates so clearly.
55. This is perhaps best answered by the Portman group. There may be opportunities through major organisations such as the Football Association who certainly have among their audience some of the higher consumers of alcohol, to develop new approaches. It is difficult to envisage incentives for any commercial organisation outside the drinks industry unless financially induced at considerable cost. Do industrialists have any better advice? It may be that those of us in professional care are ill equipped to answer this question.
- 56/59. The issues raised in this section of the consultation exercise involve some complex abstractions from the work of health economists. We do not consider that a well informed answer will be within the scope of this organisation's competence, and respectfully suggest that Christine Godfrey's work be taken as a very clear and well researched evidence base to assist in formulating a strategic response.

60. There is plenty of evidence that sensible alcohol consumption **outside working hours** does assist **some although not all people** and groups to function more effectively, as individuals or groups. There is similarly plenty of anecdotal evidence that alcohol use in these settings can impair effective networking. It is difficult to anticipate how this area of consideration can be helpfully included in a National Harm Reduction Alcohol Policy. However it does point to the importance of Workplace Alcohol (and Drugs) Policies.
61. The Swanswell Trust has developed a very comprehensive approach to the development of workplace alcohol (and drug) strategies that have been applied with a range of major employers in the private sector, and which are currently being applied in major NHS settings. **This material, produced to a very high standard, is easily available from Matt Feeley on 02476 226619, or email to matt.feeley@swanswelltrust.org.**

Conclusion

This initiative is very much welcomed by this organisation that is increasingly gaining a reputation and credible expansion for effective services in the addictions field. We would be very pleased to assist in any pilot work, or by sharing the results of very creative work that we have commissioned locally. We do hope that some of the above will be found to be relevant to the Strategy Unit's deliberations. **Thank you very much for the interest that your unit has taken in working with us, especially the excellent contribution made by Katie Law at our Warwickshire conference held at Rugby. Her contribution was so clear and articulate, and was regarded by those present as a 'high point' of the event.**

Geoffrey Cobbe
Chief Executive
2nd January 2003