

# addaction

ADDACTION is a leading provider of drug and alcohol treatment services. Founded in 1967 as the Association of Parents Against Addiction (APA) we changed the charity's name to Addaction in 1998. We now operate 53 services in England, including several alcohol specific projects comprising alcohol counselling in prisons, community-based alcohol counselling, two residential units, and alcohol arrest referral. We have a great deal of experience in delivering a range of drug treatment services linked to the drug strategy, and see opportunities for cross-fertilisation from this work which may be applied to alcohol treatment. We hope that alcohol treatment will be high up on the Government's agenda when the alcohol strategy is published in 2004.

We run day programmes for drug treatment and testing orders, community drop-in centres, drug market response, shared-care prescribing, young people's services, prison programmes and harm reduction services including needle exchange.

Our experience on the front line delivering both drug and alcohol services and our professional expertise gives us a particular insight into the issues that may usefully inform a new alcohol strategy.

**Peter Martin**  
Chief executive

## SECTION ONE

### THE PRINCIPLES THAT SHOULD UNDERPIN THE STRATEGY

#### 1. Why should the Government get involved in managing the harmful effects of alcohol misuse?

There are plenty of reasons why Government should get involved. Significant harm is caused by alcohol misuse at significant cost to individuals and society. Misuse leads to anti-social behaviour, violent crime, domestic violence and disorder. 15 million working days are lost because of drink related problems.

The impact on health is well documented - from injury and accident to psychological problems and chronic medical conditions that affect major organs of the body. The cost to the NHS alone has been estimated at £3 billion per annum. Around 50% of all road crashes are alcohol related, 47% of serious injuries, 40% of self-poisonings, and a ten fold increase in alcohol-related paediatric attendances documented in the past ten years.<sup>1</sup>

Government can help change drinking culture that can make a significant impact on alcohol misuse. It can also help people make informed choices about alcohol use. Government can help protect vulnerable people including children from harm. Government can also help by making more treatment available to those who need help with problem drinking.

An alcohol strategy is long overdue. But alcohol policy has not featured prominently on the Government agenda.

The urgent need for an alcohol strategy is underpinned by the following major concerns:

- alcohol misuse is linked to aggression and public disorder
- the current phenomenon of increased underage drinking
- alcohol misuse among parents and carers which can not only put children at risk of immediate harm, but can have negative long term effects
- the extent to which alcohol is part of a wider pattern of drug misuse
- effects of alcohol misuse on other vulnerable groups i.e. rough sleepers and those who have a previously diagnosed mental illness.

Government has the responsibility to make laws to keep order in society, to protect children and to create and implement policies for health provision and a safer environment for all its citizens.

#### 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?

The right balance needs to be struck between protecting the rights of the individual to engage in a legal activity and helping and protecting the individual and society from the harmful effects of alcohol misuse. Government needs to take responsibility for reducing the harm that alcohol misuse may cause when either the individual or the community cannot do so. At the same time, Government needs to encourage the individual to take personal responsibility.

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<sup>1</sup> Luke 1998.

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

The costs to communities of alcohol misuse can be significant. The waste of potential and the poor quality of life are common consequences. In producing a strategy, realistic objectives and goals must be allied to a commitment to place alcohol misuse at the heart of Government policy. However, the Government is likely to be reluctant to use tight legislative controls. Such developments may bring accusations of the 'nanny state'.

However, a balance may be struck by ensuring messages recognise the rights of the individual while emphasising the individual's responsibility to themselves, their families, and the community in which they live and work.

Points to promote:

- culture change through campaigns and Government advertising employing realistic messages and appropriate messages for different groups of people
- education as to the common consequences of alcohol misuse
- the encouragement of safe environments for drinking and the encouragement of environments that may provide alternative relaxation settings not based on an alcohol culture.
- guidelines for safer drinking so that it can be pleasant for those drinking and does not have a negative affect on those around them
- effective evidence-based help and support for those at risk from harm.

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

All have responsibilities to ensure the law is maintained and do what they can to ensure that problematic drinking is discouraged.<sup>2</sup>

Commercial interests require monitoring to ensure they comply with the law. There is evidence of a direct correlation between the marketing of certain drinks such as 'Alco-pops' and similar fashionable drinks and the rise in consumption by young people - particularly young women.

- clear information about the number of alcohol units reflected in the contents and how much is the recommended safe level, should be clearly marked on these drinks along with the percentage level of alcohol contained in these drinks
- marketing techniques such as offering these drinks at cheaper prices at certain times should, in our view, be regulated.

The joint experience across the field and improving knowledge of 'what works' has already resulted in a shift in Government drug policy with a greater emphasis being placed on treatment within the drug strategy. An increased focus on treatment within an alcohol strategy is required. Drug policy has also been placed within the Home Office, a spending ministry with specific powers. Ownership of policy on alcohol would usefully be placed within a relevant ministry with powers, with close joint-working between other relevant Whitehall departments.

Drug policy has faced competing priorities and different agendas between health and criminal justice<sup>3</sup>. But drug policy has embraced treatment within the criminal justice

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<sup>2</sup> Also see: Young People's Exposure to alcohol –the role of radio and television, Liverpool, John Moores University 2002.

setting and increased emphasis on treatment in this area has to be applauded. The relationship between alcohol misuse and crime still requires more research. There is nevertheless a general acceptance that alcohol misuse is linked to crimes of violence rather than acquisitive crime.

There may be useful cross fertilisation of ideas between drug services and alcohol services while recognising that there are differences in alcohol misuse and crime and drugs. The government can also learn much from those in the voluntary sector who currently deliver drug treatment because they have the experience of working within a Government led strategy. Some of those drug services, including those within Addaction, also deliver services for people with alcohol problems.<sup>4</sup>

- The voluntary sector should have a clear role to play in developing policy.

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

- a. honesty
- b. integrity
- c. commitment
- d. joined- up- policy
- e. a belief the right of all children to live safer happier lives and the willingness to intervene to ensure these rights are upheld
- f. the right of all people who need help to get appropriate help in a timely manner
- g. proper resources and ownership at the local level
- h. recognition of cultural differences
- i. clear and long-term objectives
- j. no reliance on quick fixes
- k. individual rights should be upheld as far as possible
- l. clear and appropriate (non- stigmatising) definitions are necessary, e.g. harmful, misuse, person with a drink problem, dependency
- m. definitions should be agreed
- n. mixed messages need to be challenged
- o. clarity and consistency are vital
- p. strategy MUST be multi-agency.

## SECTION TWO

### THE CULTURAL AND BEHAVIOURAL ISSUES AROUND ALCOHOL USE AND MISUSE

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

Alcohol use is misuse when it adversely affects the individual, children, the family, the community and the economy.

Alcohol possesses enormous potential for misuse because it affects the individual's brain chemistry thus altering mood and reducing the individual's control over both its effects and use. It can remove the individual's ability to take personal responsibility. Denial that there is a problem is a common characteristic of progressive alcohol misuse by the individual.

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<sup>3</sup> Alcohol misuse may cause criminal behaviours in an individual who is not dependent on the substance. However, underlying patterns such as a mental health problem may induce alcohol misuse leading to criminal behaviours.

<sup>4</sup> E.G. Addaction Brighton in partnership with Community Alcohol Team Projects sees 40 per cent of clients with alcohol problems. Addaction also runs two alcohol arrest referral projects in Devon and Cornwall.

There are a large number of factors to be considered when defining alcohol misuse – personal misuse and consequences and the broader misuse that affects society.

**Factors:**

**1. General**

- alcohol availability and accessibility
- trends that currently show an increase in consumption and an increase in hazardous drinking by certain groups- particularly the young and women
- culture
- social and economic pressures.

**2. The individual:**

- personal history
- family history of use and misuse
- family relationships
- other relationships
- quantity of alcohol consumed
- physical symptoms
- behavioural symptoms i.e. anti-social behaviour
- mental well being
- age
- gender
- culture
- awareness (state of 'denial' that there is a problem)
- the social and economic context i.e. housing education/skills
- employment
- environmental risk
- effects on partner and children
- child abuse
- legal issues
- safety.

**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?**

**Binge drinking**

Binge drinking is one type of problematic use. The increase of binge drinking among young people and women is well evidenced. Binge drinking presents particular dangers to health and leads to anti-social behaviour and violence.

But there has been less education about the effects of binge drinking than there has been on the general symptoms of other problematic use such as drinking every day or drinking in the morning.

(Note: the period between binges for the problematic user may become shorter over time.)

Although consequences for different types of drinking among different groups need to be consistently reinforced, an alcohol strategy for harm reduction might usefully attempt to affect binge drinking among identified groups.

(Note: drinkers who regularly drink over safe units but are still able to function normally can, with support, learn how to drink safely.)

There are also strong indications that problem drinking within the parental home by adults may also result not only in problem drinking among young people, but in psychological problems and anti-social behaviours which can affect young people's life chances. **Prevention initiatives therefore should be focused on families, upon young people and women.**

**Drink driving initiatives have been effective.** It is no longer perceived as acceptable to drink and drive. However, the messages need to be reinforced, as drink driving still results in an unacceptable level of injury and death. Change can come about through regulation and legislation underpinned by safety messages.

**Cultural change can come about through influencing perceptions of fashion:** on what is cool and not cool.

The commercial drinks industry sends powerful messages to young people, e.g. it is a 'rite of passage' to drink or 'it is cool to drink and cool to be drunk'. Advertising is increasingly skilful. Acceptability of heavy drinking patterns can be challenged by messages that focus on such consequences as the effects of drinking on looks, for example, on skin and hair condition or on offensive body odours. This could be particularly effective among the impressionable young. **The industry and its advertising should be more heavily controlled through legislation.**

Safe drinking levels (units) can be used as a useful baseline for change. **Messages need to be pitched at a level that people can understand** – for example, units combined with the equivalent measures for those who don't understand units on their own. Better education around cumulative consumption of individual drinks which proclaim the percentage of alcohol levels on the bottle i.e. 4% alcohol declared on Alco pops is not fully understood by people, particularly the young and might be compared with proclaiming a cigarette is 'light' or 'ultra-low'.

**Alcoholic drinks sold in bottles and cans should proclaim unit levels on the container.**

**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?**

Generally, the focus needs to be twofold - towards provision of more easily accessible treatment and support, improved education and earlier intervention with young people.

Specifically, workplace culture has shifted. Drinking during the day is no longer as acceptable or encouraged in some professions as it once was. But it is still a big problem recognised by business and industry. As binge drinking has increased so this will have an effect on the workforce and on also on drink driving.

Changes in the socio-economic position of women have meant more women have the ability to enter the drinking culture.

More research could usefully illuminate the relationship between alcohol misuse and the breakdown of the family unit may have undermined family 'controls' over younger age drinking.

Similarly, more research could give us a better understanding of the relationship between stress levels resulting from increased economic and social pressures to an increase in binge drinking.

**We suggest a focus on:**

- appropriate messages for women
- workplace alcohol policies (business may consider alcohol testing)
- stress-relieving initiatives in the workplace
- improved work-life balance
- it may be useful to think about a complete ban on driving after drinking.

#### Other points:

- find ways of reducing the shame associated with problematic use thus making it easier and more socially acceptable to seek help - with an openness that is lacking in our culture. (Ideally, seeking help and self-referral should be as easily facilitated as seeking help for smoking and as socially acceptable).
- it is very difficult for alcohol misusers to seek help when there are so many obstacles in the way. For all sorts of reasons, many individuals who recognise they need help, do not want to be referred to their GP.
- some Primary Care Trusts wish to control contracts and referral pathways and in so doing, put more obstacles in the way of alcohol misusers wanting to seek help directly from specialist agencies by insisting GPs are the first point of contact.
- although GPs are a crucial part of an alcohol strategy, and any effective alcohol strategy will without doubt require an expansion in GP numbers<sup>5</sup>, there needs to be a greater choice for the individual who wants to seek help, not restrictions.
- many more open access services with flexible hours need to be established
- At A and E departments people arrive in casualty when little planned admission is possible, meaning people are not assessed and the treatment response is not planned. Planned admission leads to improved success.

**9. One group we need to focus on specifically is young people<sup>6</sup>, 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?**

From our experience in the drugs field it is clear that addressing drug misuse among particular ethnic minority groups presents particular issues. In communities where drugs and alcohol are forbidden for religious reasons substance misuse has gone “underground”\*. Appropriate investment and training of substance misuse workers to address this and the wider involvement of community leaders and ethnic community families is required. Costs of communicating with ethnic minority groups can result in inequality in some aspects of service provision and more focus on needs and proper funding is required.

\*(Ref: Bengali Community, Addaction Tower Hamlets Community Drugs Team).

#### Women:

Additionally, women, and young women have not fully understood the extra risks facing females who drink problematically. Alcohol can damage women’s bodies faster and can affect fertility.

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<sup>5</sup> The role of GPs who are well trained in alcohol misuse and treatment is vital, but Addaction recognises that there is currently a shortage of GPs, and additional work will impact on this problem.

<sup>6</sup> 2002 schools survey by Department of Health showed binge drinking among 11-15 year olds has doubled in ten years and pinpoints Alco pops as contributing to the increase.

**Children with parents or carers who misuse alcohol:**

Systems for identifying children in families where the parent or carer has a history of a heavy drinking need to be improved. We need trained family support services in these cases.

**Poor parenting and neglect:**

There is a correlation between poor parenting and alcohol misuse<sup>7</sup>. Child abuse can be about neglect, emotional abuse as well as physical abuse.

**Access through YOT:**

Effective interventions with young people may be made through Youth Offending Teams (YOTs).

**Adult services inappropriate for young:**

Young people with substance misuse problems should not be treated within adult services but in dedicated young peoples services.

**Cross sector training by specialists:**

Training of all those working in the statutory and voluntary sector with families by specialists within agencies such as Addaction and others can help raise the capability for identification and referral to treatment.

**Parental Support:**

Parents with children who misuse alcohol need help in developing support groups.

**Domestic Violence:**

Drink-related domestic violence is a recognised major issue requiring specific intervention and support. Identification of domestic violence and alcohol problems within the family unit is vital in order to prevent further harm.

The need to address the developing crisis in GP shortages is even more urgent and we need to seek alternative solutions and offer linked support to GPs by for example closer working relationships with trained voluntary workers.

**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?**

Historically, alcohol use has provided a useful mechanism for social engagement and acted as a safety valve for the release of feeling. It is a welcome feature of celebrations and can help some people feel more at ease. If it weren't for alcohol, other illegal substances may be substituted.

However it is possible to express positive feeling without the prop provided by a mood altering substance. This fact is not widely acknowledged.

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

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<sup>7</sup> Unpublished research funded by the Nuffield Foundation covering found councils in London revealed parental substance misuse affects more than one-third of all cases dealt with by social services. "Alcohol problems lay behind 41 of the 100 family cases dealt with and was combined with drug problems in a further 27 cases". It found that although parents' alcohol misuse caused the most harm to children, social services were much quicker to react if crack cocaine or heroin were involved.

There is a drinking culture, but it has mutated over time and different trends are evident at different periods.

#### Historically:

Alcohol in the form of ale and other cereal-based alcohol were used by the British in the absence of clean water. Alcohol was produced commercially by religious institutions. Alcohol was embedded in the rituals of ecumenical life. For centuries, alcohol has been part of our culture and has played a role in the social history and the biological evolution of our people. Alcohol use has long been viewed as a rite of passage into adulthood.

The history of social control on alcohol consumption shows more direct intervention from religious movements than from the State. The UK is now an increasingly secular society and religious influence has reduced, and increasingly responsibility for guidance and control has been placed on the State. (see questions 1 and 2 above)

#### Why we drink?

We may use alcohol and go on to misuse alcohol for a variety of reasons. Alcohol produces chemical changes in the brain that can stimulate cravings. Alcohol misuse may have roots in historical, evolutionary, sociological and environmental factors. There may be a mixture of these and other physical genetic factors. Our need for mood altering substances may be the result of the previously mentioned change in a dependence on faith-based systems for support, or indeed in a general existential anxiety where there is an impulse for human beings, unlike the animals, to escape from the knowledge that they will die.

#### Gender trends:

Heavy drinking was once viewed almost entirely as a male preserve. Greater equality and purchasing power has ensured the 'laddish' culture now translates into the phenomenon of 'ladette' culture.

#### Environmental issues:

Some public houses seem totally geared up to heavy drinking and some are not child-friendly. Few coffee bars open in the evening, so it is difficult to find social meeting places not centred around alcohol.

Particularly in the north of the country where beer is cheaper heavier drinking patterns may result.

#### Sport:

There is a culture of drinking and sport that has been influential on drinking patterns. An opportunity may now exist for influencing reduction in drinking through using sporting role models.

#### Other perceptions:

Drinking culture and "job" culture are often married in people's minds, but may not necessarily reflect reality.

**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?**

Factors:

- family background
- Inability to express feelings (immaturity)
- lack of self-awareness
- isolation
- Increasingly secular society with no easily identifiable alternative for 'spiritual' comfort
- fear – of crime, violence, terrorism
- peer pressure
- fashion
- advertising
- media messages
- information technology
- fame culture and the behaviour of 'role' models
- adult behaviours seen as hypocritical towards drugs while accepting alcohol
- availability of alcohol and other drugs
- accessibility
- children who have a parent with an alcohol problem
- reactive factors – (e.g. 'Alco pops' introduced to boost sales of alcohol to young people that had slumped with the widespread use of ecstasy, or reactive factors such as more disposable income.)
- health
- hygiene.

Family background, peer pressure, social fashions and disappearing belief systems – the food for the 'soul' that used to be provided by organised religion are the most influential factors exacerbated by all the other factors.

To exert influence requires gaining people's attention and then to follow through by encouraging change. Unless there is strong leadership and real importance placed on strategy and policy the opportunity for influence will be reduced. Peer influence, influence within the school environment, attention-grabbing campaigns that make an impact through government advertising, coercive measures for focusing attention on penalties for alcohol related behaviours, the support of sporting and other role models may be the easiest routes to influence and culture change.

In the workplace, an increase in effective occupational policies for alcohol use and misuse that are well publicised, accompanied by appropriate pathways for referral for help supported by the employer may be also be helpful means to influence.

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

It depends what the risk is and how it equates with the individuals aspirations for themselves and also at what age an individual is presented with those risks. Potential for change often occurs when the individual is open to change through having personally experienced loss or injury from alcohol misuse. Some people don't worry about the effects on their health of heavy drinking until they begin to experience severe consequences. Young people are particularly resistant to messages about physical health risks of alcohol. Young people, are more likely to respond to messages about negative effects on personal looks and hygiene.

As mentioned in (7) above, drink-driving messages about risk have been effective in reducing harm.

We know enough about the risks and we know enough about what factors exacerbate risk. But more work needs to be done to identify those individuals and groups who are at risk.

### SECTION THREE

#### HEALTH: PREVENTION, TREATMENT AND THE IMPACT ON THE NHS

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

Also see question (6) above.

Alcohol use is harmful when it adversely affects the individual or others people.

People have different tolerances to alcohol. Symptoms might involve certain behaviours that point towards problematic use. An individual may not recognise they have developed a problem and may present with problems such as anxiety or depression which after investigation are clearly alcohol related.

Clinical tests may show high levels of alcohol in the bloodstream.

Gender, race, age and some other factors such as poverty leading to under nourishment may play a part in how tolerant an individual is to alcohol. Other socio-economic factors - cheaper alcohol such as 'scrumpy' can be more toxic than expensive champagne.

Those who suffer from any or all of the following may be at risk from problematic drinking:

- low self-esteem
- poor coping mechanisms
- lack of confidence
- social exclusion
- under-achiever.

Indicators for people who may have a drink problem:

- feelings - of anger, depression, anxiety,
- needing a drink every day
- drinking alone
- needing a drink to stop trembling
- drinking first thing in the morning
- a strong compulsion to drink
- spending a lot of time on activities involving alcohol.

any one of the above or all of them may indicate problematic use.

Alcohol can, for a time, change feelings, but these feelings are not long - lasting and ultimately can also have the effect of inducing the feelings which alcohol was taken to prevent, for example, to alleviate depression and anxiety. This is the so-called 'merry-go-round' of compulsion to drink that keeps individuals rooted in the same spot without change.

Identification of cause and effect is a complex and problematic area for doctors and consequently for statisticians. We suspect huge numbers of people who have alcohol problems are being missed by the health system –because of lack of training, lack of knowledge and understanding, and the overall lack of routine testing. Such testing for alcohol misuse in the primary care setting as well as within hospital A and E and trauma departments would help improve identification of underlying alcohol problems and causal links. The consequent improvement in knowledge would inform policy and improve care planning and response.

There are likely to be large gaps in identification of problematic drinking and its effects on life chances, work, education, personal relationships, and involvement in anti-social behaviours and harm to others.

Identification of problematic use requires skilled assessment. If identification and referral procedures were more widely deployed by teacher, school counsellor, police officer etc, this would close gaps and improve care.

**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?**

There are a lot of addiction studies available, many conflicting. There is much more research on alcohol and its effects in the US than on the UK population. But there is good statistical data available on alcohol consumption in the wider population<sup>8</sup>.

We know that alcohol misuse is a major cause of attendance and admission to general hospitals in both the A and E, trauma and non-emergency setting<sup>9</sup>.

The visible burden on the NHS has been placed at £3 billion<sup>10</sup>. The Strategy Unit's own scoping note makes reference to "a 1997 report" suggesting the cost to the economy (including an economic valuation on the years of life lost or YLL due to premature death) at between "2% and 5% of a country's GDP".<sup>11</sup> The World Health Organisation (WHO) refers to a figure of between 1.5% and 2.1% of GDP. Accepting 2% as the cost of YLL this would give a cost of £20 billion per annum at current prices. (This is referenced in more detail in the World Health Organisation's international guide for monitoring alcohol consumption and related harm (2000).

The WHO YLL figure does **not** include the cost of legal and police costs associated with alcohol related violence or with a wide range of less visible social problems such as divorce and child abuse.

Contrast these figures with a report that in 2001, the UK accrued £7 billion in revenue from alcohol sales.<sup>12</sup>

More credible research is needed over longer period of time.

Additional specific data from Addaction:

Useful data collected from the system used by Addaction for monitoring substance misuse among its clients is fed into the regional drug misuse database and includes alcohol misuse information. We also implement more detailed periodic user surveys to help inform our plans for services and to help inform government policy and plans.

On health benefits:

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<sup>8</sup> Citing just one –the General Household survey 1998 –more than one in three men and one in five women in the UK regularly consume more alcohol than the recommended sensible limits

<sup>9</sup> Alcohol, can the NHS afford it –Royal College of Physicians 2001.

<sup>10</sup> Alcohol –Can the NHS afford it –Royal College of Physicians 2001 and Alcohol Concern

<sup>11</sup> Kopp et al (French) study 1999- referred to 1.5% of a country's GDP in YLL, also Harwell et al USA 1992 study – "2.1% of GDP".

*Alcohol-related death and disability account for even greater costs to life and longevity than those caused by tobacco use, according to the global burden of disease study sponsored by the World Health Organization (WHO) and the World Bank. This study puts alcohol's global health impact on a par with unsafe sex and above tobacco in terms of its contribution to the total number of years of life lost to death and disability as recorded in Disability Adjusted Life Years (DALYs). In addition to chronic diseases that may affect drinkers after many years of heavy use, alcohol contributes to traumatic outcomes that kill or disable at a relatively young age, resulting in the loss of many years of life to death or disability.*

<sup>12</sup> Community Care – P 23, 19<sup>th</sup> December 2002

Periodic research, sometimes funded by the drinks industry, has shown the benefits of moderate levels of alcohol to some specific physical health i.e. red wine for the heart. However, other research has shown red wine may have a deleterious effect, showing links between certain types of alcohol and some cancers.

Overall, there are conflicting messages e.g.

“too much alcohol will harm you” v “some alcohol can help protect your health.”

Generally drinking in moderation is perceived to be acceptable and “healthy”.

**16. What are the costs to 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.**

For direct costs to the NHS see (15) above.

Apart from injuries caused by alcohol related accidents and violence, medical studies have connected alcohol misuse to many underlying medical conditions, showing effects on many organs of the body including deleterious effects upon the immune system.

Alcohol misuse may also affect those staff that work within the NHS

**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?**

- promote openness through government campaigns about the effects- no one is immune to the effects if they abuse alcohol
- much greater accessibility to skilled advice and treatment at an earlier stage, including speedier access to detox and on-going rehabilitation
- linked approaches between criminal justice and treatment services i.e. in alcohol arrest referral.

Greater capacity for identification of alcohol as a root cause of specific problems through:

- education and early intervention with the young at school and within families
- knowledge-based training – and far more of it particularly with regards to identification of dependency, long term effects and the models of treatment management within the medical setting (Improved education should be a requirement of the undergraduate curricula in medical training).
- a change of culture within the medical profession to go beyond treating the presenting illness, towards tackling the underlying alcohol dependency as a root cause
- more resources in psychiatric services
- improved liaison between mental health trusts and acute hospitals to enable closer identification of alcohol related mental health needs as identified by the Royal College of Physicians.

- more front line experience in treatment of dependency in the training process
- a much stronger and closer relationship between the medical profession and the voluntary sector alcohol treatment agencies particularly at the local level
- screening for alcohol misuse in routine health care
- the delivery of longer-term care plans supported by the hospital (on discharge) and the GP and other treatment groups within the community
- good trained and accredited counselling
- assessment protocols required to improve identification of needs wherever a person presents with an alcohol problem, (currently there are weaknesses and inconsistencies)
- consultation and involvement of 'users'
- consultation and involvement of former users who are sober in voluntary mentoring programmes
- an understanding among the judiciary that like drug use, relapse is part of recovery
- on- going research and audit – including the mapping of geographic and demographic levels of dependency and matching data service provision in a planned way
- an increased emphasis on education around positive messages: i.e. How others have managed their problematic drinking – case histories and the benefits of living without alcohol.

Backing of policy with muscle at every level- i.e.

- Government lead on alcohol policy should be a senior role
- the raising of alcohol policy to be the joint responsibility of the Home Office and the DH with responsibility for management of health care at a micro level to devolve to the NTA
- the DAT remit to formally and mandatorily include alcohol
- the improved training of commissioning DAATs
- placement of responsibility of alcohol treatment at a senior level within hospital Trusts and mental health Trusts.

**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?**

Brief interventions can work if professionally delivered but they don't work for everyone, especially those with entrenched drinking patterns and other related problems. In the primary care setting they are more likely to be effective when supported by trained staff.

Although most treatment is delivered outside of the hospital setting, when alcohol treatment is managed in the hospital setting it is not managed particularly well or consistently. There is a postcode lottery in hospital detox and care. Often slow processes including long waiting times for psychiatric support and lack of any continuum of care will impact on an individual who has sought help and found help wanting in this setting. Resources, structure and training are wholly inadequate to deal with need<sup>13</sup>. Alcohol misuse does not receive the priority attention it deserves.

Medical staff in the hospital setting and GPs in the primary care setting are inadequately trained in alcohol misuse.

As with the delivery of interventions for drug related problems, aftercare is crucial and often needs to be long-term.

**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?**

We still do not fully understand the causes for alcohol dependency. However, there is evidence that treatments do work.<sup>14</sup>

Current treatments work for some people and should be tailored to individual needs. The top three interventions according to cumulative evidence of a major analysis of controlled trials<sup>15</sup> are brief intervention, motivational enhancement therapy and social skills training

Project MATCH (1997) was a large clinical alcohol treatment trial that found the treatment modalities of a) motivation enhancement therapy, b) 12 step facilitation and c) cognitive behavioural coping skills performed equally well.

As with drug treatment, the post medical care in alcohol treatment for those with moderate to severe levels of dependence, is longer term- often requiring care for underlying psychological problems, and other care- which addresses the broader needs of the individual such as bereavement, low self - esteem, and practical needs such as housing, education and training. The objective is change; initially to remove the cravings for alcohol and manage withdrawal and on-going care, to support life changes which can help the individual to function and grow without dependency on alcohol.

Substitution of alcohol by another drug should never be long term unless specifically identified as in psychiatric prescription for an underlying psychiatric illness.

Availability of services is very patchy. Services are probably more flexible in the voluntary sector.

We would want to encourage commissioners to think more about aftercare services, more effective care pathways, integrated services and easier routes into rehab. Models of Care should be systematically applied to alcohol treatment as they are being in the drug treatment field.

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<sup>13</sup> In Eastbourne and Wealden where CATP (Addaction's Partner in Brighton and Hove runs a service, £72000 per annum is given by Government to deal directly with community alcohol problems among a pop. Of 257,000.

<sup>14</sup> Review of the effectiveness of treatment for alcohol problems Raistrick (Leeds Addiction Unit) and Heather ( Centre for alcohol and drug studies, Newcastle. 1998

<sup>15</sup> The Mesa Grande Project Miller et al 1995)

Suggest that services should be mapped, structured, planned and commissioned on the 'tiered' model in common usage for drug treatment.

Need earlier interventions and need to address advertising and messages about where to go for help.

As mentioned in the response to question (8) above, for all sorts of reasons, many individuals who recognise they need help, do not want to be referred to their GP. Some Primary Care Trusts wish to control contracts and referral pathways which seem to serve to put more obstacles in the way of alcohol misusers wanting to seek help.

#### **What can we learn from drugs prevention and treatment?**

- people can change and treatment works for all kinds of people
- longer term joined-up commissioning making provision for continuity of care is vitally important
- availability, accessibility and equality are all crucial components of quality treatment
- investment in training for skilled alcohol/substance misuse workers for the voluntary sector is important
- training people who work with vulnerable families and young people within social services, probation, health service, police
- services for long-term problematic users need to be integrated to care for the whole person
- the value of using role models and peer education (peer mentoring)
- user consultation promotes 'ownership' and helps plan services for need
- the need to reduce shame and stigma
- the need to provide dedicated young peoples services
- need to tackle prejudices in relation to accessibility in order to improve use of combined substance misuse services. Combined substance misuse services are important and effective models for delivery. But as in the issue of 'crack' users, there are entrenched attitudes which can work to prevent people with alcohol problems attending services that they think are not for them. These attitudes need to be addressed and challenged.
- a multi-agency approach
- leadership at a high level within Government necessary
- the recognition that effective outcomes take time
- a multi-faceted approach to prevention and education is required
- support and training across relevant professional sectors can help identify problems and assist appropriate referral
- more resources targeted at hard to reach groups and particular areas of deprivation
- need to have A and E referral services paralleling arrest referral.

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

The link between alcohol misuse and aggression and alcohol and violence is well documented. Prevention through campaigning and presenting the evidence of the violence and harm that can arise is just one of a multitude of responses required to improve safety and reduce harm. The wider use of plastic containers and drinking vessels may be one way of reducing harm (although the drinks industry has been resistant). This has environmental implications.

Anger management and role playing and similar educational interventions by those most at risk of losing their control and behaving violently may be required as more routine part of treatment interventions particularly in the criminal justice setting. Messages about safer drinking in the home and workplace and occupational policies required to address safety.

**21. 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?**

Alcohol misuse can cause mental health problems as well as being a symptom of an existing mental health problem.

Studies by the World Health Organisation and also by the UK-based organisation The Samaritans, links suicide to alcohol misuse in many cases. Alcohol can act on the brain to increase levels of depression and thoughts of death and can add impetus to the act of suicide.

All services require improved liaison and co-ordination to avoid waste, duplication, poor identification and inadequate response.

Stronger working relationships between relevant services at the local level is required.

## SECTION FOUR

### CRIME, DISORDER AND ANTI-SOCIAL BEHAVIOUR: THE EFFECTS ON OUR SURROUNDINGS AND COMMUNITY.

**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 the gaps in evidence?**

More evidence is needed about alcohol related crime. Generally, alcohol-related crime is linked to injury caused by violence or to drink driving.

Some reports listed in footnotes: <sup>16</sup>

There is currently no strategic pathway for the routing of direct evidence on harmful effects of alcohol.

Individual agencies such as Addaction supply broad client information based on data collection to the Regional Drugs Misuse Database. But we are also collecting information on alcohol misuse. Addaction produces periodic 'user' surveys that can help us plan services and can provide useful information to government. These are not commissioned but produced on an ad hoc basis.

We also produce periodic evaluations of outcomes as recently with our Alcohol Arrest Referral service in Cornwall that showed a 23% reduction in re-arrests for the same offence by those accessing the AAR.<sup>17</sup>

<sup>16</sup> Policing and Reducing Crime Unit (2000) briefing note 9/00 Crime and Disorder Partnerships. Home Office. And Report Alcoholis Volume 20 Issue No 4 (2000), Johnathan Harrop –Probation Service – Alcohol related offending and the work of the Probation Service.

<sup>17</sup> AARS Addaction 2002 – Impact of Alcohol Arrest Referral Scheme on re-arrest figures: Of 59% of those eligible for and who passes the Arrest Referral Scheme, 23% were re-arrested less often than those who were arrested for the same offence the previous year.

There is more evidence of the relationship between drugs and crime, although criminal behaviour has been reported in some studies as pre-dating drug use.

Drug misusers are at risk of transferring dependency to alcohol.

**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?**

We have anecdotal evidence of the link between alcohol and violent behaviours. We have the potential to collect more data through our data collection programme in the future and through our user surveys.

(Violent crime including domestic violence, criminal damage, drink driving, disorder). One-off drinking sessions can act as “flashpoints” leading to violent acts and out of character drink driving. Generally alcohol related crime is not pre-meditated (unlike drug-related crime) and is often forgotten by the perpetrator.

**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?**

Young people as a whole may be unfairly targeted and blamed for disorderly behaviour –where high spirits may be mistaken for job behaviour actually perpetrated by a small minority. Fear in certain communities may result in targeting certain groups unfairly.

Alcohol can be demonstrated as a factor in disorderly behaviour convincingly - via statistical evidence, especially looking at the timing of incidents, i.e. coinciding with pubs closing, and at the point of arrival at A and E departments. Here, record keeping is important to provide evidence of violent/criminal behaviour. Research into domestic violence has also evidenced statistical links to alcohol use and violent behaviour towards a spouse or child.

**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?**

Other factors may include:

- late night food outlets as congregation points
- location of taxi ranks
- licensing hours
- homelessness.

Planning and licensing laws should not simply be the responsibility of the police and the local authority. Involving young people and community representatives in planning policy, environmental design, graffiti policy, public transport, and initiatives on safe places to congregate could help.

Need for a multi-agency strategic response within the community.

**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?**

Problems tend to be concentrated in certain settings in urban areas whereas it is less visible in rural communities and tends to be more tolerated.

There is increased drink driving in rural areas and a lack of police presence.

The risk of being banned from the only available public house for miles may reduce the level of trouble caused by drinkers in rural areas.

- 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?**

The drinks industry made it clear they were not in favour of plastic glasses because of cost.

In Cardiff, one initiative was to have bottle banks readily accessible, and in some towns and cities total drink bans in the street have had some effect.

Council planning departments could ensure that applications meet the need to avoid clusters of pubs, taxis, parks and food outlets forming 'drinking' ghettos.

- 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?**

Community Safety Partnerships such as those established under the 1998 Crime and Disorder Act and bring together local emergency services, local authority services, police and probation, are examples of partnerships that can work well at a local level for drugs. Their work could be transferred to deal with alcohol misuse issues and could include the work of licensing forums. Lack of a strategy and finance and additional data protection issues may inhibit progress. Fear and a sense that nothing can be done also inhibit initiatives. Need local leadership.

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

They do need to be targeted, but not exclusively. The drinks industry that targets young people. Mixed messages and adult behaviour –do as I say rather than do as I do – alienates young people and can reduce the effective targeted messages.

- 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?**

The new licensing laws will have advantages and disadvantages and should be linked to education initiatives and effective controls. Not enough emphasis on continental approaches, encouraging more family restaurants and cafes, where the emphasis is less on drink than in British pubs.

- 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?**

Problems in perception, i.e. between the pub and club culture. Need to increase police powers to close down unruly premises, not putting the responsibility on police on the beat to continually tackle the same places. The powers are there but need proper enforcement and clubs should not be exempt.

- 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?**

Need to use Section 17 of the Crime and Disorder Act and think about the location of licensed premises, especially in residential areas

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

The law has made drink-driving socially unacceptable. Very tightly controlled with no "get out". Generally the public welcome drink-drive initiatives as they can see the direct impact on them and their community.

- 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?**

Helpful interventions via domestic violence specialists in police and probation, links to women's refuges, anger management groups, reactive not preventive, could be improved. There are some countywide domestic violence strategies ( i.e. in Devon) but not everyone is aware of it. Sure Start could contribute to family support initiatives. Sometimes agencies don't make the link between domestic violence and alcohol misuse. Possibility of providing specialist alcohol support to domestic violence units.

## SECTION FIVE

### THE IMPLICATIONS FOR VULNERABLE GROUPS

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

It would be a mistake to assume that any would be exempt. But some are more prone to peer pressure and those children and young people who are less well supervised or those who may have a parent or two parents who drink heavily, especially if domestic violence takes place.

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

Those who are socially excluded, people who have been in care or other institutions, victims of abuse, former drug misusers who see themselves as "downgrading" to alcohol, those who attempt to self-medicate for conditions such as depression with combinations of alcohol and other drugs. Those who live alone in rural isolation. Some elderly people who are isolated.

- 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?**

Social exclusion, unemployment, inadequate housing, poverty, no access to leisure or learning. Interventions need to be based on a menu of tailored items, possibly part of structured day programmes with an integrated whole-life approach and including group work components aimed at raising self-esteem etc. Also need to consider the opening hours of services to make them as accessible as possible for those who are

trying to get back to work and possibly influence the business community to produce alcohol in the workplace policies giving people agreed time off to attend services.

**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?**

Joint initiatives do exist, especially in the criminal justice field i.e. Prolific Offender Units, DTTO schemes, arrest referral and many of these are monitored or influenced by community safety partnerships. A fine example in Addaction services of joined up commissioning and close working relationships is Addaction Derbyshire<sup>18</sup>.

In some local areas Priority Action Teams (again, initiatives that have arisen in some areas from the Crime and Disorder Act 1998) take on alcohol issues at a local level – banning drinking in town centres and so on. All of this work is patchy and varies depending on the political will and the ability to make cash available. One obstacle to joined-up working can be a clash of ideologies among different agencies, i.e. regarding harm minimisation and abstinence.

A focus on process rather than outcomes can hinder. A focus on internal priorities and agendas can hinder. A lack of common in different agencies standards can hinder successful referral and monitoring. A belief in some statutory services that it is wrong to fast track ‘offenders’ into treatment can hinder. Control of resources for treatment by those with different agendas and priorities can hinder.

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

This depends on the assessment of the individual and which tier of service is appropriate. There should be a range of options available and a recognition that we are dealing with individuals who may share one common problem but will respond to and need different interventions. Not many cognitive behavioural therapy programmes are in place that deals with alcohol and this could be addressed.

## SECTION SIX

### EDUCATION AND COMMUNICATION

**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?**

To help change culture by presenting clear, concise and consistent messages which are realistic and appropriate for the various audiences. Also to inform people, including children, where they can and will receive appropriate help.

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<sup>18</sup> Addaction Derbyshire, the first Addaction fully integrated drug service commissioned for Derby and, and three satellite areas in southern Derbyshire from 2000 initially offered drop-in, complementary care, ASRO and DTTO programmes, shared-care prescribing, IT training, links to local colleges, housing and general health advice. The service has expanded to include training of drug workers, cross sector training for those working with young people, a dedicated young person’s service, close working relationships with local parents support group, and the first Drug Market Response Team working in an ‘umbrella’ partnership with peer agencies and the police.

- 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?**

An example of effectiveness is the drink-driving campaigns which were easy to understand and made direct and consequential links between excessive drinking and harm.

- 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?**

Messages about units do not seem to be getting through – variation in interpreting what a unit is and some examples of people “saving up” their units and binge drinking.

- 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?**

A general judgement is - not as well as it might. Scientific research often conflicts and can cause more misunderstandings than it resolves. The healthful alcohol use v damaging alcohol use paradigm is a case in point.

Scientific research however is crucial to enhancing our understanding of addiction, and why some people develop problems. Scientific information is often presented to audiences in inaccessible ways. Some scientific research may be biased and needs to be examined by genuinely independent bodies<sup>19</sup>. Information about consequential behaviour and harm is more relevant to general education.

- 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)?**

Need to give clear messages about the harm associated with alcohol use universally, although it may be of use to stress the dangers of lone drinking for elderly people.

- 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?**

Education about alcohol misuse, consequences and management in these settings is appropriate and useful. Must be built in to community/life studies and to stress harm to health and communities. Peer education initiatives can be useful, although a multi-faceted approach to education is required. There is some evidence that using peers who have experienced alcohol misuse and come out of treatment, can, on their own present the idea to young people that alcohol misuse is something you can go through and survive.

- 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?**

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<sup>19</sup> Reference recent report that exposes alleged infiltration of WHO by the food and soft drinks industry to bring undue influence to bear on research and recommendations on food, soft drinks and obesity issues in nations' health. (Guardian Sarah Bosely Jan 8<sup>th</sup> 2003)

Parents and families are role models for children and the way they behave will have more impact than what they say. Joint educational initiatives, informing parents and children together will ensure consistency and could be offered through schools.

**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?**

Messages are more effective if they are consequential and emphasise the detriment to the individual and/or his/her surroundings and significant others. The “just say no” type of campaign is ineffective.

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

Don't use the “just say no” approach. Hysteria does not help, but a range of messages that are realistic which people from different groups can identify with, is important. Shock tactics are part of the response, because they can make people sit up and listen in a world that is information heavy, but can only be useful as part of a broad strategy. Input from former problematic drug users can be effective.

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

Yes –need much tighter control. Health warnings could be issued as with cigarettes.

## SECTION SEVEN

### THE SHAPE OF THE MARKET AND MARKET-BASED SOLUTIONS

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

The consumption of alcohol is likely to increase. Commercial pressures on young people to drink and party will increase, new ways will be found to make drinks and mixes more 'hip' and to make bottles and labels more attractive. Alcohol content levels seem to be increasing in lots of products.

**51. 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?**

Need to be truthful and make links between current trends and uses/misuses of particular types of alcohol, e.g. “ vodka and red bull gives you energy”. Increasing use of “happy hour” leading to binge drinking, lots of supermarket offers, “buy one get one free”

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

Wherever there is a need and a commercial pay off, there will be research, even if it is also motivated by altruism. If such a “magic pill” was created people could sober up immediately, leading to reductions in problems such as drink-driving or domestic violence. This would be useful harm reduction. However, the physical effects on the organs from misuse would not be prevented and such developments could delay identification of other serious physical or emotional problems that underpin the alcohol misuse.

**53. 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?**

Joint education initiatives with the industry about safe and enjoyable drinking levels, warnings on bottles and adverts etc.

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

Insurance – could refuse to insure if history of drink driving. Every commercial employer has a vested interest in the well being and safety of staff and the introduction of alcohol in the workplace policies could be more extensive, looking for signs of misuse and making provision for help and support.

## SECTION EIGHT

### 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 well being for many, part of the work on the projects will be to form a clear picture of these costs and benefits.**

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

The evidence on economic costs is far greater than the evidence on benefits.<sup>20</sup> There is enough evidence to warrant immediate action and investment in an alcohol strategy but more research is required.

**56. 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 costs in lost education to building a healthy workforce. The real cost in delays in identification of alcohol problems in the primary care setting. The costs of poor care planning in the hospital setting.

Benefits- more conclusive data required on the benefits of alcohol in reducing certain illnesses and therefore reducing care costs to the NHS. This would need to be balanced with the cost to society of and resulting longevity.

The economic benefits to workforces involved in the alcohol industry

**57. 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?**

The drinks industry should contribute more to costs of treatment and to efforts to reduce harm. Individuals responsible for drink-related crime should be dealt with under the law. Society generally pays for the costs to the NHS and

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<sup>20</sup> Alcohol Concern Report March 1 2002, WHO data on DLL referred to previously, and Home Office and DH Studies

Government has a responsibility to ensure that these costs are reduced by producing an effective policy.

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

Alcohol is a large source of revenue to the Exchequer. While high prices of individual drinks may help curb some excessive use, there is an underlying moral argument for investing money raised into treatment for those who develop alcohol problems. The alcohol industry keeps people in jobs.

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

Studies in the USA have examined the effects of alcohol links and educational attainment and found them to restrict attainment<sup>21</sup>.

More research required on alcohol use and occupational attainment.

Some discourses have exploded the myth that excess alcohol use benefits art and writing.<sup>22</sup>

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

Workplace initiatives do exist. Addaction like other agencies has been involved with 'business' in helping to develop strategies for drugs and alcohol use in the workplace – a cause of major concern to business and industry.

Getting people back to work following difficulties with alcohol needs to be addressed in any strategy.

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<sup>21</sup> The Higher Education Centre for Alcohol and Other Drug Prevention released a new publication by H. Wesley Perkins, and David W. Craig, titled "A Multifaceted Social Norms Approach to Reduce High-Risk Drinking: Lessons from Hobart and William Smith Colleges." This work provides a detailed example of coordinated social norms strategies producing positive results confirmed with extensive evaluation measures in alcohol use and misuse in colleges.

<sup>22</sup> WRITERS AND ALCOHOL *By Ann Waldron* The Washington Post - March 14, 1989, pp. 13-15 (c) The Washington Post