

National Alcohol Harm Reduction Strategy - Consultation.

Barnsley Drug, Alcohol and Tobacco Board Response

What do we want to know?

National Alcohol Harm Reduction Strategy.

The principles that should underpin the strategy

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

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

The Government is concerned with alcohol and alcohol misuse on several levels; through taxation, legislation and licensing, health, social inclusion, education and citizenship.

The Government should get involved at a national strategic level – developing a national strategy that local agencies can implement to suit the local needs. There is no evidence that national government management at a local or operational level works. The Government should also support local initiatives, especially strengthening local multi-agency working. The Government should also ensure that resources to address problematic alcohol use are both distributed equitably across the UK and ensure there is the appropriate balance between resources for alcohol services and illegal drug services.

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?

Individual freedom of course, brings about individual responsibility. The Government also has a moral responsibility to all its citizens to ensure that they reach their full potential. It is apparent that alcohol misuse causes problems on many levels; from anti-social behaviour, to the economic cost of lost days at work, the Government has to intervene.

The Government should model treatment interventions based on the National Treatment Agency and 'Models of Care' (DOH, 2003).

Since the Government has a health department, it could be said to be negligent if no sound health advice is given out. Therefore, Government should gauge to what extent its role in delivering the health message should be. Examples of successful persuasion to modify behaviors can be found in the national campaigns on drink driving and seat belt use.

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

We see this consultation as a good start to that process. There should be extensive consultation with the public and community groups to better reach such balance. Within Barnsley we are doing this through a series of 'community summits' to promote understanding and debate of the complex choices faced by individuals and communities.

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

The scope for answering this question is too wide to give justice to in our response. It is clear that there are many differing roles and responsibilities associated with alcohol, and it also clear that some of those roles and responsibilities conflict on practical and philosophical levels, two examples:

The Government has a responsibility to ensure the health and safety of its citizens on the one hand, whilst generating enormous tax revenue from the sale of alcohol on the other.

A town council wants to regenerate the local economy, much of which is from the leisure trade on one hand, yet has public order problems in the town centre in the evenings on the other.

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

The overriding principle that should underpin the strategy is that of inclusiveness. A National Strategy needs to be owned by the Nations stakeholders.

In addition we would like to suggest the following principles:

- Realistic Goals
- Adequate Resourcing
- Regular review
- Compatible with Human Rights Legislation

There should be a clear emphasis on alcohol as a lifestyle issue with personal responsibilities and consequences, such as the 5-a-day campaign for fruit and vegetables. Do not allow alcohol to become a 'drug issue', and dominated by police, courts, custom and exercise etc.

The cultural and behavioural issues around alcohol use and misuse

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

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

Alcohol Misuse is defined as: When the individual, family, or community as a whole is negatively affected by alcohol use. These may be characterized by persistent or individual incidences of alcohol misuse. The negative effects include: Physical and Mental health, finances, social functioning and criminal or anti-social behaviour.

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?

The Government should seek to balance the individual freedoms of a Democracy with the moral responsibilities it is mandated for. The Government should be aiming to have an effect on; excessive drinking, drinking levels that cause the most harm and anti-social behaviour.

The Government should ensure that any prevention Programmes are fully evaluated in terms of outcome on a pilot basis before implementing any National Prevention Programme

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?

There are possibly links here, though we are not aware of the research in these areas. There may be a link to changing leisure patterns.

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

Any strategy needs to be as inclusive as possible, different groups will have different needs and issues.

Increasingly children as well as young people are group that requires focus.

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?

There are millions in the UK that do not experience problems with their alcohol use, many of those people meet and socialize around venues where alcohol is present.

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 ages groups?

We cannot generalize on an English 'drinking culture' though it is true to say that there are differences in the way the English and say, the French view and use alcohol. There are

regional differences and trends in drinking patterns, as well as amongst different social groupings.

There may be patterns of drinking associated with different age groups, for example status drinking 18–30, and relaxation/ pain relief drinking in later life.

Violence at and associated with football matches may be linked to alcohol consumption.

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?

The Media and advertising undoubtedly plays a major part in influencing people. Behaviour is affected by all of the above factors that have been mentioned above. It is easier to exert influence in the shorter term, reactive factors, such as media reporting and legislation, than it is in the longer term behavioural factors such as environment.

Peer influence cannot be underestimated when considering factors that influence behaviour.

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

Risk is an important part of most people's lives from the risk one may take by buying stocks and shares, to the weekend rock climber. Alcohol is a disinhibitor; people's attitudes to risks can be altered due to alcohol consumption.

Young people growing up naturally take risks as part of the journey to adulthood. Many young people do not see alcohol consumption as particularly risky. Attitudes to risk are often affected by the immediacy of action vs. consequence. A long term view of alcohol related disease is not uppermost in young people's minds when drinking, rather the more immediate consequences such as hangovers.

Health: prevention, treatment and the impact on the NHS

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

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

Harmful drinking is that which causes physical and/or, mental and/or, social harm to the individual.

The concept of harmful drinking is much more useful than the old ideas of alcohol misuse. A new strategy that is underpinned by the concept of harmful drinking is much more likely to succeed.

See Stevens and Raftery series of Health Care Needs Assessments (Alcohol Misuse chapter) for categories of drinking.

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?

We would guide you to Alcohol Concern and DrugScope who are far better placed to comment on research and evidence than us. There are gaps in outcome research relating to Alcohol Prevention/Education.

The BMJ website can provide recent articles where people have concentrated on costs of alcohol use. Notably, the article by White et al models risks and consumption.

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

We believe that the costs to the NHS should be measured in short and long term issues. In the short term there are the A&E visits due directly and indirectly to alcohol, and subsequent bed space and inpatient costs. There are also short and long-term recruitment issues facing A&E Departments, which in some part may be attributable to anti-social, drink related behaviour.

In the long term there are the costs related to alcohol dependency treatment and alcohol related long-term health issues such as Liver Disease. The statistics on in-patient days for liver disease and alcohol withdrawal are easily obtainable.

The costs to the NHS as an employer should also be taken account of. Occupational health services for secondary care staff are generally good however; occupational health for primary care staff is still in its infancy. There is little doubt that doctors and dentists are known to have high rates of alcoholism.

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

The most appropriate means of prevention must be through consistency. Safe drinking levels need to be based on sound research and not change without due evidence. There needs to be a national, post qualifying training programme that can be accessed by all to ensure that the messages are consistent across professional disciplines.

Having 'Lifestyle' clinics in primary care may help people review their nutritional choices and alcohol use. In this way primary and secondary prevention may be addressed in a nonspecialist, non-threatening way, increasing the chance of uptake of services.

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 have shown to be effective in several pieces of research. In identifying people at risk there needs to be more proactive, multi professional approach.

A research project could be developed to test how effectively community workers, or lay people are compared to NHS staff in delivering brief interventions. It is not the case that all interventions need to be conducted by doctors or nurses.

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?

Any interventions should promote good health and lifestyle choice, rather than denounce alcohol in the same way as illegal drugs.

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

The last 2-4 years have been a turning point in the treatment and care of people with substance misuse problems. The development of the National Treatment Agency has shown to be effective in change implementation. Many drugs services are ‘evidencing’ their work through outputs and outcomes. The NTA has been instrumental in guidance to commissioners of drugs services; many of the same principles apply when looking at alcohol treatment.

There needs to be a range of service responses to alcohol treatment, similar to drugs treatment; Counselling, medical treatment, detoxification and rehabilitation, complementary therapies, nutrition and dietary advice.

Treatment needs to be easily accessible, confidential, of quality, and free.

In terms of prevention, particularly primary prevention, the picture is less clear. We know of no outcome studies that show major behavioural change as a result of prevention Programmes.

The Government should not consider alcohol like drugs, but more in the model associated of cigarette use and tobacco control.

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

Plastic glasses and bottles in pubs and clubs. Harsher penalties for anti-social behaviour.

Drinking abstinence orders for offenders. Compulsory anger management and alcohol education courses for offenders.

Community based reparation orders have proved effective.

Much has been written in the BMJ about A&E and alcohol problems.

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

Our understanding is that alcohol plays a contributory factor in the majority of suicides, Alcohol concern estimate that 70% of men and 40% of women have consumed alcohol before attempting suicide. Alcohol, as a central nervous depressant is often used to self medicate symptoms in people with mental health problems. There is no doubt that undiagnosed psychiatric condition can be masked by alcohol use and made worse leading to depression.

Similarly to the current thinking in relation to other drugs, we feel there needs to be better use made of a multi disciplinary dual diagnosis approach.

Coordination for all alcohol related activities (including recommendations on licensing?) could come through the Drug Action Team structure, many areas, including Barnsley have included alcohol in the DAT process.

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

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

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

We believe that the Police should routinely record alcohol consumption, as a contributory factor in crimes perpetrated, and a national database should be kept to analyse key trends and statistics. We believe this has previously been done by police forces.

We refer you to the recently announced Strategy Unit study and scoping note into tackling the problems associated with alcohol misuse (Cabinet Office 19.07.02)

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?

Evidence should be sought from the National Probation Agency.

We refer you to the recently announced Strategy Unit (as at question 23), particularly to the section on ‘Violence, Crime and Disorder’.

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?

We do not have any evidence as to alcohol as a factor in criminal and disorderly behaviour, though we suspect it plays a major part, certainly in anti-social behaviour. Perception is rarely close to fact. The media plays a major role in fuelling perceptions.

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?

Licensing must play a major factor, the density of pubs and clubs in a particular area. As you have stated, transport and design both play a part.

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?

We suggest that in urban areas there are more likely to be different groups/ strangers drinking in a high-density area; with all the issues associated with that scenario. In a rural area it is more likely that the people drinking will know each other and there are less violent crime and disorder issues. However, there may be more incidences of drink driving associated with rural drinking.

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?

See answer 21.

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?

We believe that a multi-agency approach is the right one to take. Partnerships between statutory agencies and with voluntary and community groups are becoming the preferred approach; lessons should be learnt from what has already been successful and applied to drug.

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

The evidence seems to suggest that the majority of victims and perpetrators are in under 25's age group.

We believe that it may be slightly easier to change behaviors and perceptions in this age group than older age groups.

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?

Yes.

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?

Town centre bans for individuals committed of offences is one possibility, as are alcohol abstinence orders. Where public drinking becomes problematic, local authorities should be implement more no drinking zones.

We refer you to the newly announced Licensing Bill.

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?

Not that we are aware of. We feel that guidance is needed in this area, particularly regarding consistency.

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

Drink-drive policies were not effective immediately, but through years of sustained, consistent and renewed messages.

Driving licenses are perceived to be valuable, both in terms of employment, leisure activities and status that people are reluctant to risk.

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?

Alcohol should certainly never be regarded as a mitigating factor in domestic violence. Greater support needs to be given to victims and greater penalties to perpetrators. Victims of domestic violence need to be able to access appropriate help and support immediately.

The implications for vulnerable groups

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

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

The children of alcohol misusers are probably the most vulnerable. Children that are excluded from, or truant from school and young offenders.

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

Anybody that has faced major trauma, such as refugees, major disaster victims and so on, are susceptible to self-medicating with alcohol.

Children and young people in general face serious effects on their developing bodies when drinking too much.

People who are homeless as a result of drinking.

People with mental health problems.

People in areas of deprivation, with high levels of unemployment and low incomes.

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?

Better research needs to be carried out into the area of mental health and alcohol misuse, anecdotally we would see many people with mental health problems that misuse alcohol. We agree that the problems are complex.

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?

Shared and owned values with joint commissioning and service specifications can lead to better joined up service provision at a local level.

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

All care plans and pathways need to be individual, rather than, service led. We recommend the 'Models of Care' approach.

Education and communication

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

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?

We do not believe that prevention alone can alter behaviour, rather, it is a combination of prevention, media, legislation, social and peer pressure. Raising of awareness is always a primary aim of prevention and should continue to be so. People make choices in a multitude of ways; reactive choices, proactive choices, choices based on their peers, laws, availability and so on. The drink-driving campaign narrowed the choices, to drink and drive is wrong, it kills, the perception of the choice therefore was psychologically important, when the choice boiled down to drink and kill, or not, most people prefer not to kill.

There has been a paucity of national publicity on the risks of alcohol, particularly when much advertising concentrates on branded drinks for consumers.

The objectives at present should include promoting debate on sensible drinking levels.

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?

Effectiveness must be measured longitudinally as well as for immediate effect. The evidence for the drink-drive campaign can be seen in the related drop in offences and accidents involving alcohol.

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?

In terms of young people, the message does not seem to be getting across. The message on sensible drinking suffered a setback some years ago when the sensible drinking limits were changed, seemingly arbitrarily, some weeks before Christmas. Sensible drinking limits should be as familiar as the benefits of eating fruit and vegetables, and getting exercise. We live in a much more fitness-orientated society, we should 'piggyback' this trend.

The further regulation of alcohol advertising should be examined, as the sensible drinking message has to compete with significant levels of alcohol advertising.

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?

We feel unqualified to respond to this question.

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)?

There is little doubt that messages, whilst remaining consistent in content, need to be tailored for specific groups. In certain situations the messages would need to be more intensive than at other times.

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?

Alcohol education should be cross curricular, we believe that there has been insufficient resourcing in this area, and the perception is that drugs are more dangerous, based on resourcing and prevention and education activity.

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?

There is great scope for parental and family involvement. The 'Sure Start' programme is a good example of this, which could be extended to over 5's.

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?

Barnsley is currently investigating peer group activities.

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

We are unsure, as there seems to be little evidence of the effectiveness of drugs prevention/education.

This issue should not be categorized as an illegal drug issue.

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

We believe that there should be a complete advertising ban of alcohol on TV and in cinemas. There should be no advertising hoardings for alcohol within 100 yards of schools. Funding should be made available for advertising that reflects the negative effects of alcohol. Clear health warnings similar to tobacco should be utilised. Labeling on glasses in pubs and on bottled drinks and cans should also have health warnings about consumption and hazardous levels.

The shape of the market and market-based solutions

The drinks industry is a major part of the national economy. It provides large numbers of jobs both in supply and distribution; it influences trends and fashion through its advertising; and it provides a substantial portion of tax revenues. Understanding how that market works, what drives it and how it responds to demand is essential to producing an effective strategy.

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

The alcohol industry should be active partners in the national alcohol harm reduction strategy. The alcohol should be encouraged to take voluntary steps to contribute to the reduction of alcohol related harm.

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

Positive promotion (such as tax benefits) of alcohol free or sensible drinking lifestyles needs to be proactive. Government might offer incentives such as tax relief on positive advertising.

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

Research in this area is crucial, future responses should be based on sound findings of what works.

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

Through a partnership approach.

Better labelling is needed on alcohol products to show clearer information, perhaps a 'banding' system; Alcohol free, low alcohol, medium alcohol, high alcohol and very high alcohol, to be boldly displayed.

A national scheme similar to 'investors in people' could be introduced whereby responsible parts of the industry could benefit.

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

There should be no tax, or even subsidies on alcohol free drinks in pubs and clubs to encourage less alcohol consumption. Venues offering alcohol free areas could be given tax incentives and benefits.

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 project will be to form a clear picture of these costs and benefits.

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

We suggest Alcohol Concern and DrugScope be approached regarding this question. The Centre for Health Economics has studied the cost-effectiveness of alcohol services and the wider economic picture in relation to health costs and benefits.

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

We suggest Alcohol Concern and DrugScope be approached regarding this question.

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

The Government and the alcohol industry receive most of the income from alcohol sales, therefore they must be held partially responsible for the costs. The Government should apportion part of the tax generated on alcohol to treatment and education; similarly the alcohol industry should apportion a percentage of their profits.

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

The alcohol industry is a significant part of consumer spending, and is of benefit in regenerating the business community, much of which is dominated by leisure.

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

We feel that the question answers itself somewhat.

This depends upon good occupational health services, which should be available to all employees. It is also linked to mental health promotion issues. There is no doubt that alcohol affects cognitive function and can therefore affect functions and productivity at work.

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

There should be greater use of Employee Assistance Programmes as utilised in the USA.
See question 60.

If you would like to contact us to discuss this response please use the details below:

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