

British Psychological Society
Response to the Department of Health
National Alcohol Harm Reduction
Strategy

Compiled by the Division of Clinical Psychology (DCP)
Faculty of Addiction, with contributions from the Clinical
Psychology Specialists working with Older People and
the Faculty for Children and Young People.

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?

Alcohol use and misuse can result in major costs to the health and health care systems, to crime and the criminal justice system, and to Society and the social care system.

It is more cost-effective to prevent a problem than to treat the symptoms of a well-developed condition. The earlier the intervention, the better the chance of success and the greater the chance that the individual can maintain their level of productivity within Society. This principle is well accepted in the NHS.

Government should not be paternalistic with regard to alcohol use, but does have a responsibility to ensure that a comprehensive approach to alcohol and alcohol issues is taken through public health and public order legislation and the provision of treatment services. Government ought to intervene when the consumption of alcohol of an individual or group causes other people to be disturbed or harmed.

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?

Alcohol misuse is always a matter of individual responsibility (except for a small minority with severe mental health problems); it is ultimately the exercise of choice and the individual cannot absolve themselves. However, there is a point at which a person's drinking does become deleterious to their health and/or to Society. When an individual's drinking prevents others from living or developing within socially accepted norms (for example children, the elderly and the victims of domestic violence), it is at that point that the Government has responsibility to ensure the safety of the community as well as the individual. It is also the Government's role to ensure that individuals whose drinking has become harmful can access treatment/help.

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

The individual has the right to freedom of expression and belief, but only as long as it does not conflict with the collective rights of a society/community. The European Human Rights Act will need to be considered in relation to this issue.

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

Consumers: to use a readily available psychotropic drug (i.e. alcohol) sensibly, responsibly and appropriately. Consumers also have a duty of care to others who may not use alcohol appropriately and should assist in the prevention of harm.

Voluntary Groups: It is unclear to what this refers. If it is voluntary agencies, their role is to provide low threshold easy access helping services, especially those interventions at the less formal end of the treatment spectrum (i.e. Tier 1 and 2 services within *Models of Care*). It is of

paramount importance that voluntary and statutory agencies work in conjunction to provide interventions such as alcohol education, advice and counselling. Voluntary agencies need easy access to statutory treatment services, to make direct referrals for individuals requiring specialist support and to help each other in developing working practices. Voluntary agencies have a valuable role as advocates for clients and are ideally placed to provide help and support for those affected by the problematic drinking of others.

Commercial Interests: to provide safe drinking environments and to educate and train employees in matters relating to alcohol use. Furthermore to ensure responsible and accurate marketing and clear labelling of products.

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

There should be a serious commitment to a national policy, coupled with sufficient financial resources to make the policy succeed. The policy must be evidence-based and objective, rather than subjective. For example, there is a wealth of evidence to show that alcohol misuse is a disorder of behaviour which will respond well to psychological and social treatments: there is no evidence to suggest the condition is a disease, although clearly diseases can result from alcohol use. (Health Technology Board for Scotland, 2002). The principle of early intervention remains important.

Social, economic and cultural elements all have a relationship with trends in drinking which, in an ever-changing Society, is difficult to address. Most people drink in environments where rules exist (e.g. public houses) and although the rules are seldom clearly displayed, they are generally internalised by people and obeyed. An effort to understand the principle of “rule absorption” could assist in the development of “rules” for other circumstances in which alcohol is consumed, such as at friends’ homes or in a public place.

The policy should allow service providers to address locally identified needs and provide appropriate, evidence-based treatment.

The cultural and behavioural issues around alcohol use and misuse

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

Questions

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

There is no simple way of defining alcohol misuse. It is a complex syndrome resulting from the interplay of different individual factors. It would not be our recommendation at this stage for a national alcohol policy to attempt to generate a consensus definition of alcohol misuse, when this has eluded the field for so long. Different cultures or social groups have different definitions of problem drinking and no consensus exists at all as to what constitutes binge drinking.

Given this complexity, alcohol misuse cannot be defined in terms of ‘units of alcohol’ or indeed ‘safe limits’. Any future definition would have to encompass the complex *pattern* of consumption, the consumers’ own view of their alcohol use (e.g. whether they perceive their own drinking to be problematic), coupled with the health, social, legal and personal difficulties related to that alcohol use. It is important not to be restricted by simple definitions, e.g. the alcohol dependence syndrome, or the cluster of symptoms outlined in DSM-IV or ICD-10.

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 strategy should include all patterns of alcohol use that have a deleterious effect on the person's psychological, social, economic or domestic environments, and should seek to affect all those patterns.

Alcohol misuse is not a passive condition and the motivational enhancement approach in treatment is based on the premise that, "everybody has their price", meaning that if change is perceived as worthwhile, people will do so. In addition, the more social support there is for the altered pattern of drinking, the more chance there is of that change being maintained.

'Prevention' has no product, therefore success can only be measured in an abstract form i.e. the absence of something. There needs to be a commitment to prevention without the expectation that cause-and-effect data will be available and hence targets reached. At best, correlation data will be obtained.

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?
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?

Normal drinking amongst adolescents is generally characterised by high session intake with infrequent drinking episodes. It is known that as people age, their sessional intake decreases whilst the number of drinking episodes increases. This data is obtained from a normal sample of males, not from a sample of problem drinkers. Spontaneous disinhibited behaviour would be expected to occur on occasions amongst the younger drinking population, given their lack of experience with alcohol, but future problematical alcohol use is not inevitable.

Young women are drinking more as part of the wider picture of female emancipation, freedom, earning power etc. They are more visible now as drinkers and are presenting more of a public order problem because of their presence and visibility.

Older drinkers (age 65+) are identified as a potentially vulnerable group, yet the Alcohol Concern Directory (2001/2) cites twenty-seven health authorities operating age limits for statutory alcohol services. Standard One of the NSF-Older People is to 'root out' age discrimination for all health and social care services and so is an issue in need of address.

It is becoming apparent that problematic drinking in the older age groups is increasing and that there are serious health risks, including problems around the effects of medication and alcohol, increased risk of falls, and the connection of dementia and alcohol misuse.

It is important to look at the collective data whilst looking at local trends. The strategy will need flexibility so that different groups can be targeted in different localities dependent upon need e.g. Asian, young men.

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?

Positive cultural and behavioural aspects of alcohol use:

- Facilitates family rituals/celebrations (e.g. weddings)
- Forms part of religious events/feasts (e.g. Christmas, Communion)
- Creates profits for the drinks trade and industry
- Lubricates social/community spirit (e.g. pubs,)
- Helps to celebrate watching sports/activities (e.g. football/cricket/rugby matches)
- Acts as a non-medication-based relief of stress plus some positive health benefits e.g. heart disease
- Provides income from taxation from the brewing and distilling industry
- Provides employment in the drinks industry/restaurant/leisure trade
- Encourages social cohesion and lubricates socialisation
- Facilitates the creative arts (music, writing, comedy sketches, etc)

Most parts of our culture would be deleteriously affected if alcohol was total taken out of the equation. We are a drinking and drug-taking Society and the government strategy needs to aim towards the reduction and minimisation of harm rather than the abolition of drinking.

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

The English public house is a respected social institution and a safe, controlled drinking environment in the majority of instances. Safe drinking environments should be further developed and encouraged.

There are huge regional variations in beliefs and understandings about alcohol consumption, often related to the industry of the area (e.g. stockbrokers vs. miners) as well as the socio-economic factors. Therefore there are social deprivation factors that create sharp district as well as regional differences.

The English drinking culture looks different for different age groups; that is inevitable. Although looking at the general drinking population is helpful, it is also important to understand the ageing process and place 'excessive' drinking in the context of age. Young people take calculated risks to include drinking alcohol and this risk-taking decreases with age. We need to develop specific interventions for the younger, working age and older drinkers that are properly evaluated as part of fluid local treatment strategies and linked to health promotion schemes.

There is also the "yob culture" aspect in which excessive /binge drinking is acceptable and also a measure of the strength of the individual.

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

All of the above factors influence drinking behaviours and no one factor dominates. Behaviour is dependent upon regional characteristics, cultural influences and opportunities. Perhaps the most influential in terms of alcohol misuse per se is the family/social networks that support safer and/or controlled drinking. What also needs inclusion however, are influences relating

to: attitudes, exposure, experimentation, experience and environments (social, economic, cultural, racial).

The ease with which influence can be exerted through the family and/or social network hinges on the willingness of the key people in the problem drinkers' lives. If the interest and willingness to be involved is there, then it is easy to influence and maintain change. However it is difficult if such significant others are not willing to participate. Families are very established in their acceptable patterns of living and have well entrenched habits, which can be quite difficult to change.

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

There are risk-takers and there are non-risk-takers in our Society. The attitudes to risk are affected by alcohol consumption (you get less aware of risk with increased intoxication). Young people are more willing to take risks, but it is calculated risk and it is complex. There is not a single or a simple equation of how attitudes affect risk.

Health: prevention, treatment and the impact on the NHS

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

Questions

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

There is no simple definition of harmful drinking (see question 6). The factors that need to be taken into account in deciding whether 'heavy drinking' has become 'problematic drinking' include social, physical, psychological and legal consequences. The drinker's view of his or her drinking would also have to be considered, as would opinions of significant others affected by the 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?

Messages given to the general public are frequently both inconsistent and confusing because of a lack of consensus opinion amongst the experts.

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.

There are numerous direct and indirect costs to the NHS and include: presentations to A & E, employee sick days, increased workload for GPs, exacerbation of mental health symptoms, increased deliberate self-harm (overdose, suicides), assaults/crime leading to physical

injuries (self and others) and long-term physical health consequences leading to premature death.

Indirect costs: impact upon the wider family and social system

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.

- 1) Good quality assessment of multiple needs in a variety of settings (e.g. primary care, voluntary agencies, mental health services, general hospital wards, youth services, etc.).
- 2) Motivational enhancement therapy to get people engaged in the helping process.
- 3) Behavioural skills training with in vivo practice (rehearsal).
- 4) Community reinforcement/social network therapy to support behavioural and attitudinal changes.
- 5) Practical life skills training to deal with other problems such as housing, benefits, self-care, etc.

Forms of training most appropriate for professionals must go well beyond the classroom format, which only has limited impact on professionals' changes in attitudes, knowledge and behaviour. Specialist skills training involving practical experience through shadowing specialist workers, secondments to specialist services, working with specialist services in a co-operative way and good quality clinical supervision is the way to change professionals' behaviour and attitudes.

Professionals in training to work with alcohol misusers must have an interest in this client group for if not, they can do more harm than good. It is more cost-efficient to concentrate on those staff who want to work with problem drinkers and they will then influence their more reluctant colleagues over time.

It would be folly to disband specialist services in favour of training a generic professional workforce. The specialists' expertise and willingness to work with the more complex problem drinkers will always be needed, but in addition to supporting the generic workforce by working co-operatively together. As with the Government Guidelines on Dual Diagnosis (DoH, 2002), Specialist Alcohol Services should be in addition to and not instead of generic professional workers.

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 (BI) work well only if the professional worker has specialist knowledge of alcohol treatments as well as brief intervention treatments. The evidence does not support the use of BI for drinkers with serious and complex alcohol-related problems. Those at risk are not well identified in generic settings. Generic practitioners, for example, tend not to ask the key questions about drug and alcohol use often because they do not know what to offer next if the person identifies a problem. There is a considerable lack of knowledge regarding local specialist help/support for their patients or indeed for themselves if they wish to treat the condition. Fear and a sense of incompetence often plague generic workers who lose their

sense of role competency and role adequacy if they do not receive the support and guidance of specialist alcohol workers. Specialist alcohol workers can also provide a treatment consultancy and training role for those employed in primary care and secondary care settings.

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?

Good review of the research evidence: *Prevention of Relapse in Alcohol Dependence. Health Technology Assessment – consultation assessment report*. Health Technology Board for Scotland (2002)

The major effective treatments that work are based on sound psychological principles and have been developed and researched primarily by psychologists. We are dealing with a complex behavioural sequence confounded by idiosyncrasies in the individuals environment. It is generally accepted that there is no “magic bullet” that exists for the heterogeneous population of problem drinkers. Therefore, the solution needs to be complex and flexible. Individualised care plans are essential, but with good clinical supervision of the workers.

The configuration of treatment services depends upon where a person lives. Treatment services and approaches also depend highly on the individuals who work in Specialist Services, their training, orientation, and their degree of autonomy. Community-based treatments that take services out to the clients (vs. centralised clinics) but with small in-patient detoxification units for the few who need hospitalisation, seems to be the best combination in terms of cost- effectiveness. Detoxification should be one small part of a comprehensive treatment programme that deals with psychological, social, behavioural problems as well as the physical problems related to alcohol misuse.

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

That for a strategy to be successful, the Government must recruit the expertise of the specialist workers throughout the country. Dictating the shape and form of treatment services from Whitehall using a formula not universally accepted by clinicians does not encourage recruitment or retention of specialist workers. The reputation of the National Treatment Agency, with its management style and attitudes, has resulted in a tarnishing of its reputation amongst many clinicians.

Commissioning services by means of the *Models of Care (2002)* reduces flexibility in working practices of specialist workers and seems to stifle co-operative working between agencies. It also discourages the development of local initiatives by attempting to introduce the concept of a “one treatment fits all” model.

The over-medicalisation of services also induces dependence on treatment services and prolongs the drug/alcohol problem much longer than community-based services, which generally place the onus of responsibility for change upon the individual.

Multiple routes of accessing services are important for a diverse clinical population so it is important to look to developing alcohol specialist workers in a variety of settings. Any setting that is easily accessible to those people concerned about their own or other peoples’ drinking should be invested in for alcohol interventions: primary care services, homelessness services, mental health services, criminal justice system, voluntary agencies, A & E, general hospitals, specialist liver wards, as well as public libraries, internet services etc. It is important

to have agencies who accept self-referrals, on the grounds that referrals only through other agencies (e.g. GPs) create barriers to accessing effective specialist treatment services. A variety of low threshold access points are needed in each locality.

Treatment has to be consistent, internally robust and valid to the individual client. Treatment services must not be subjective and based on value judgements of professionals. They have to make sense to the individual and match his or her expectations and needs for interventions. There needs to be a range of interventions available, and the stepped care approach has the best potential for the complex users.

The “Just say No!” message of prohibition has been repeatedly demonstrated to be an ineffective way of addressing substance misuse, often alienating the individuals it is intended to target. Drinkers (as are drug users) are not a homogeneous group of people and it is known that diverse clinical populations require access to diverse treatment services.

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?

- Drinking vessels and bottles made from safety glass to be used in pubs and clubs.
- Decent, well thought through alcohol workplace policies that are supported by trained alcohol specialists.
- Support/training for bar staff, licensed door people, publicans in order to create safe drinking environments.
- Taxi/public transport systems to remove people quickly from city centres at closing times.
- Pubs/clubs staggering the closing times. With the abolition of licensing hours, staggering closing times should be a requirement of Magistrate Courts.
- Licensed door people and bar staff to have training in first aid and conflict resolution.
- With 1 in 3 falls in the elderly being alcohol-related (NSF- OP), careful assessment and] care needs to be completed for the older population.
- Christmas Crimestoppers campaigns that focus on drink-driving.
- Consequences for the establishment of bad behaviour on premises (e.g. clubs fined/closed for illegal drug use on the premises)

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?

Note that there are immediate risks of acute ingestion/intoxication and that there are cumulative risks to health and social welfare.

There is the immediate risk of alcohol and overdose, alcohol interaction with medication and the disinhibitory effects of alcohol with some medications (e.g. Prozac). Alcohol can cause, exacerbate or be used to medicate/cope with mental health problems. It can reduce the effectiveness of medication, psychological, social and occupational treatment interventions. It can increase the likelihood of purposeful and accidental self-harm and suicide.

Dementia is identified as one of two priority areas for the development of mental health services for older people (NSF – OP). There are well-established links between chronic consumption of high levels of alcohol and risk of certain forms of dementia including vascular dementia and Korsakoffs dementia. Assessment, treatment and care strategies need to be sensitive to such conditions in later life.

Refer to *Dual Diagnosis Good Practice Guidelines* (DoH, 2002) for the co-operative working

model. Need to also consider interventions focused on others including: family, social network, educational system, primary care personnel. Need to consider alcohol misuse amongst people with severe mental health problems – which is prevalent and has a significant impact on treatment, social functioning, resource costs and contact with the Criminal Justice System.

Make services truly accessible to older people.

Look at how we address older peoples needs for intervention at lower drinking levels and adopt a health promotion approach.

Good care planning and co-ordination, addressing the holistic needs of the individual.

Clear joint working protocols and information –sharing policies reflecting a truly integrated and coordinated approach.

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

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

Questions

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

Alcohol and criminal behaviours are variously linked:

- Alcohol as a causal factor in crime e.g. violent acts when intoxicated, crime to fund alcohol use
- Crime as a causal factor in alcohol use e.g. 'Dutch Courage' to commit crime, alcohol use to cope with pressures of a criminal lifestyle
- Alcohol *is* the crime e.g. drink-driving, underage drinking, smuggling

Links are complex and not mutually exclusive; they are best understood within the individual's context.

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?

Alcohol can be linked in a variety of ways with habitual and spontaneous or impulsive offending (see Q 23) covering a wide range of crimes. Similar offending behaviour patterns are seen in people who do not use alcohol. The complex interactions are best understood at an individual level and it would be an error in judgement to over generalise about the types of crime committed under the influence of alcohol, extensive research has indicated alcohol is a significant factor in a high percentage of instances of domestic violence.

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

Research evidence and a vast number of individual self-reports clearly link alcohol use with crime and disorder, a view which would most probably be supported by the casual observations of many a witness of the average weekend night in Anytown, UK. Behaviour is directly influenced by perceptions and beliefs, thus behaviour and perceptions shape the experience of reality

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?

Factors influencing crime and disorder:

- Poverty and social deprivation
- Lack of vocational opportunity and earning potential
- Beliefs and expectations
- Self-image and esteem
- Low level of education
- Poor individual and social behavioural boundaries
- Pressure of universal closing times: -
 - i. Encourages the 'drink up quickly', 'squeeze a few in before time' strategy of drinking as the social norm
 - ii. Deposits large numbers of intoxicated individuals simultaneously, increasing the potential for conflict.

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?

Urban and rural communities have both similarities and differences in the way alcohol is used and misused. Urban environments offer more diverse opportunities for alcohol use, with a perception of less chance of detection and punishment for disorderly behaviour. In rural communities, socialisation is often focussed around the local pub and individuals rapidly become 'known' for deviance, which results in direct repercussions and often social exclusion. Consequently, rural locations often impose helpful boundaries around drinking, but equally the opposite can be true with shared patterns of dependent drinking being the socially accepted norm.

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?

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?

Factors impacting upon 'combined efforts' of services: -

- Who has 'ownership' of information
- Confidentiality
- Lack of clear joint working policies

- Lack of time for adequate liaison
- Lack of resources to facilitate communication
- Lack of manpower

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

Whilst of paramount importance to protect young people from involvement in crime and antisocial behaviour, direct targeting of this group carries potential risks in that: -

- Inappropriate targeting may increase the number of convictions among young people, resulting in a host of successive problems as a consequence of having a criminal record, prematurely or irrevocably enmeshing people with in a criminal fraternity.
- It could have tremendous negative impact upon young people's view of self and future expectations, possibly paradoxically promoting criminal behaviour
- It may alienate young people who are the victims of crime

Criminal activity among young people needs to be viewed in a developmental context.

It would be most expedient to consider promotion of positive alternatives to crime, as to emphasise what not to do ('just say no') can be provocation to the adolescent mindset.

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?

UK drinking patterns and culture differ radically from those observed on the continent and indicate that there are a number of environmental, legislative and social changes, which could promote more positive models of drinking behaviour. The media, drama, internet could all promote positive modelling and raise social awareness of the problems associated with alcohol use. A good example has been that of the development of an alcohol problem in a central character, OB, in teen soap "Hollyoaks". The portrayal has been accurate and sympathetic and is always accompanied by contact details for information and advice resources.

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?

Legislative powers can provide effective solutions to immediate local problems such as street drinking and public drunkenness, but do not address the fundamental difficulties of the street drinking population. In conjunction with restrictive powers there needs to be the provision of areas where it is 'safe to drink', with access to treatment and support services to address the problems of this group. An example being the provision of designated premises in Camden for street drinkers where drinking on the premises was permitted.

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?

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

Lessons learned from a 10 year market research study in Leicestershire indicated that health education messages about drink-driving have to be locally-based, be evident on moving targets where drivers can see them (e.g. backs of buses, car bumper stickers, etc) on durable materials to last beyond the campaign period (not beer mats, lapel badges) and with a simple message that does not require any thinking or interpretation.

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?

More public awareness about both issues and the relationships between them is required, but must be accompanied by an increase in the resources required to respond to this population who are not actively seeking treatment or change. Again, a multimedia approach could be helpful in promoting awareness.

In any location where clients present with alcohol and domestic violence issues there should be highly trained staff that can carry out sensitive assessments in a safe setting. Of utmost importance is for the workers to have competent clinical supervision and for the clinical notes to be of the highest confidentiality.

The implications for vulnerable groups

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

Questions

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

Those with a family history of alcohol/drug problems, especially a parent.
Those who live in economically and socially deprived areas with poor quality education, poor housing and limited life options or resources (the socially excluded).
Those excluded from the education system and/or underachieving at school.
Those in the 'Looked After' services (foster care, residential homes).
Those involved in the Criminal Justice System (Young Offenders).
Those with mental health problems or behavioural problems at home or school.
Those whose peer group use/abuse alcohol and/or other drugs.

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

Elderly people either cared for in homes with alcohol misusing carers (family or residential staff or hospital staff) or isolated in their own homes.

Those across the life-span with psychological problems who develop the use of alcohol as an avoidance or coping strategy.

Family members of those with drinking problems (to include children, partners, parents).

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?

It is impossible to identify key factors when the problem maintaining the alcohol problems are so individualistic. Interventions, to be successful, will have to aim for the most prominent ones (either in terms of harm to the individual or to others) and those that would best maintain improvements in drinking patterns over time (e.g. family support systems, practical life skills).

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?

Lessons of how best to work co-operatively can be drawn from the Government Guidelines for Dual Diagnosis (Royal College of Psychiatrists, 2002). The system in the NHS of the Care Programme Approach in principle is an example of joined up delivery, however, in practice is rarely so. Other examples are split posts between for example, adult mental health and child specialities, liaison psychiatry teams, assertive outreach teams, virtual multi-agency teams. There are also specialist agencies deliberately set up to connect access to medical, social, legal and practical life services for young people (e.g. Base 51 in Nottingham).

Barriers to joined-up services include:

- Interference by central government that obstructs locally sensitive developments and relationships between agencies e.g. service level agreements rigidly adhering to the *Models of Care* (2002) document.
- Financial resources and the internal market that sets agencies competing for the same pot of money and the same client group(s).
- Lack of resources that limits the amount of liaison work necessary to work co-operatively with other agencies.
- Rules of patient/client confidentiality that prevents communication between agencies.
- Government targets that are based solely on the numbers of clients seen which puts agencies in competition with each other and creates an atmosphere of secrecy.

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?

Mainstream generic services (e.g. primary care, mental health, social services, criminal justice, etc) cannot deal with serious alcohol problems in vulnerable groups without the support from local specialist alcohol services either in the form of information, support and consultancy or clinical supervision and joint working/shared care.

Specialist alcohol services need to disseminate expertise and have enough flexibility to be able to deal with clients according to need. They therefore need facilities that are young person-friendly, elderly-friendly, accessible through mental health services, family-oriented, etc. Barriers to such flexibility are: the physical premises, the geographical location of the services (e.g. urban, rural), the mobility of staff and the willingness of other local agencies to work co-operatively.

Caution must be made about having lone, tokenistic workers or workers working in isolation from other alcohol specialists. Such support is important for peer supervision, maintenance of specialist knowledge and skills, prevention of burnout and upkeep of self-esteem and self-efficacy in working with the client group (Cartwright, 1996,1997).

Education and communication

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

Questions

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

Approaches taken regarding education around certain illicit drug use can be considered as a Template of good practice, particularly regarding the club culture and ecstasy/mdma/amphetamine use. Here the aim is for harm minimisation and people are educated about 'safe' practices. Club owners/proprietors must now provide free drinking water, quiet spaces. Young people are informed early on regarding this and so are better able to take care of themselves and make informed choices.

Education about alcohol consumption should be directed at children from age 8: how to cope with others' drinking; the stages of intoxication; all with a balanced picture of the benefits and risks.

The misuse of alcohol (as the misuse of other drugs, promiscuous behaviour, violence, eating disorders) can be a way of coping. Lessons at school around the broader issues of positive mental and physical health, coping strategies, citizenship lessons, with specific targeting at identification of those who are vulnerable to emotional/psychological distress and difficulties in relationships can be a forum in which to introduce alcohol education. In this case for example, children in families where alcohol is a problem would need to be targeted, but within the normal context of education with their peers.

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?

Parents should be expected to provide education around sensible drinking as with sexual behaviour, the management of money and debt and other substance use. We should therefore help to educate parents about new cultural issues and help them to approach these matters in a helpful way. Of most concern are those parents who are unable to provide this kind of guidance and we await evidence of the effectiveness of parenting skills courses. One key approach is to open up schools to become local community centres where parents can be invited in to be part of their children's education and can be included in the health and social education sessions.

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?

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

See 46.

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

The shape of the market and market-based solutions

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

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

Questions

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

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?

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

Legislation analogous to that in clubs. Availability of cheap non-alcohol alternatives in pubs and bars. Provision of fresh free drinking water available readily. Again consider laws around night clubs providing customers/patrons with cold tap water to offset possible dehydration and over heating when taking various drugs and dancing.

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

The economic costs and benefits of alcohol

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

Questions

56. How clear is the evidence both for the wider economic costs and benefits of alcohol? Are there key pieces of research of which we should be aware?
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?
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?
59. What are the economic benefits of having an alcohol industry? Can we easily quantify them?
59. 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?
61. Are there particularly effective workplace-based initiatives designed to tackle alcohol misuse that we should be aware of?