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post

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To whom it may concern


National Alcohol Harm Reduction Strategy Consultation Response

I am writing to add my support to the views expressed in the Greater Manchester Public Health Network response to the above consultation.

I hope that you will take due consideration of the views expressed in this response.

Yours faithfully



 Felicity Green
Director of Public Health

Enc

Chair: Evelyn Asante-Mansah
Chief Executive: Sue Assar

GREATER MANCHESTER PUBLIC HEALTH NETWORK THE NATIONAL ALCOHOL HARM REDUCTION STRATEGY CONSULTATION RESPONSE

Executive Summary

1. Introduction

- 1.1. This report provides a summary of the key points in response to the National Alcohol Harm Reduction Strategy Consultation Document from the Greater Manchester Public Health Network.
- 1.2. The comments have been grouped under the eight themes listed in the consultation document.

2. Underlying Principles

- 2.1. The Government has a responsibility to protect the vulnerable individuals.
- 2.2. Use and misuse of alcohol is influenced not only by legislation and policies but also cultural, and personal factors. The strategy will therefore require an integrated approach.
- 2.3. Partners may appear in conflict for example the National Health Service and Police Authority share the concerns about the proposed Licensing Bill but the Bill is supported by the drinks industry.
- 2.4. The adverse consequences of harmful drinking are costly to the NHS, Local Authorities, Police Authority, Probation Services and communities.

3. Key Issues for Greater Manchester

- 3.1. There are fourteen Primary Care Trusts represented within the Greater Manchester Public Health Network.
- 3.2. Data from the Health Survey for England (1994-1996) indicate that in Greater Manchester 27% of people drank 'unsafe' levels of alcohol each week. This compares with an England average of 22%.

4. Cultural and Behavioural Issues Around Alcohol Use and Misuse

- 4.1. There is some evidence to support general prevention and counselling in the work place. Key statutory agencies should lead by example and develop workplace policies to discourage alcohol consumption when at work or when representing the agency and provide support to those who are identified as harmful drinkers.
- 4.2. There needs to be greater awareness of harmful drinking in minority religions and cultures where alcohol abstinence is considered normal. Access to education or support may be more difficult. Pressure to hide problematic drinking is great.
- 4.3. The harmful drinking behaviour practiced in England and Wales is not contained within this country but it remains an issue when we travel abroad. Therefore the strategy should link closely to a European-wide policy to reduce harmful drinking.

5. Health: Prevention, Treatment, and Impact on NHS

- 5.1. Alcohol is thought to be a factor in about 3% of all cancers, cardiovascular disease, suicides and suicide attempts, accidents, harm to the foetus in pregnancy, violence and crime.
- 5.2. Young people (aged 16-24 years) in particular men, are the heaviest drinkers. It is the most commonly used drug amongst children aged 11-15 years.
- 5.3. Alcohol consumption is related to socio-economic factors causing concern about the resulting health inequalities relating to alcohol consumption.
- 5.4. The World Health Organisation (WHO) defines alcohol consumption into hazardous, harmful and dependent consumption. However harmful drinking may vary according to age group and context for example any alcohol may be harmful in young people or when driving or using machinery.
- 5.5. There is a need for validated screening tools as a means of identifying hazardous drinking: e.g. CAGE, AUDIT and Adolescent Drinking Inventory questionnaires.
- 5.6. It is essential to recognise the social harm resulting from harmful drinking e.g. effect on relationships and employment or violent aggressive behaviour, as well as physical and psychological harm.
- 5.7. Staff should be trained to pro-actively seek the influence of alcohol in when patients present with major and minor injuries. Signposted support groups should be available.
- 5.8. Brief interventions therapy has been found effective in non-dependent alcohol users in the Primary Care setting. It is not a substitute for specialist treatment in more dependent users.

6. Crime Disorder and Anti-Social Behaviour: The Effects on Our Surroundings and Community

- 6.1. Action is needed to stop the development of inner city ghettos for harmful drinking. The police recognise that at night cities tend to fill with young people drinking in a harmful manner and the absence of role models drinking within safer limits.¹
- 6.2. The compulsory use of safety glass, which doesn't shatter when broken and confiscation of glasses and bottles by door staff on exit to the street is supported.
- 6.3. Town planning to ensure all drinking establishments are not placed in one area but dispersed and mixed with venues, which bring a range of people whose sole aim, is not to drink alcohol.
- 6.4. There is strong evidence of the effectiveness of a minimum legal age of drinking. This may be combined by the requirement to produce proof of age documentation.

¹ "Alcohol: Friend or Foe" Conference organised by the Greater Manchester Police Authority. November 2002.

7. The implications for vulnerable groups, including children

- 7.1. Parental access to information and education is essential. Knowledge is needed about the alcoholic content of drinks purchased for their children. Permitting consumption of alcohol by children at home should be discouraged.
- 7.2. Other vulnerable groups in the community include children in homes where parents are drinking excessively, children excluded from schools, people who misuse other drugs and homeless people.
- 7.3. Certain professions are also recognised as encouraging harmful drinking behaviours for example publicans and other alcohol retailers and the medical and nursing professions.

8. Education and Communication

- 8.1. A key issue to ensure that health messages relating to alcohol consumption are targeted clearly to the intended audience. This should be comprehensive and targeted at different levels for different groups.
- 8.2. The Greater Manchester Public Health Network believes a better measure of alcohol consumption is needed. The alcoholic content in a "unit" of alcohol will vary greatly depending on the type of drink and by country in which it is consumed. There is poor understanding of how many units are contained in non-standard measures of alcoholic drinks consumed at home.
- 8.3. Literacy may be a barrier to obtaining information or seeking support.

9. The Shape of the Market and Market Based Solutions

- 9.1. Prohibit advertising near schools or before the watershed. Impact of hazardous drinking such as increased risk of fatal and road and other injuries, increased aggression and violence, increased high-risk sexual behaviour.
- 9.2. Clear and consistent labelling of the alcoholic content of drinks and food that contains alcohol.
- 9.3. The focus should be to promote non-hazardous drinking behaviour.

10. The Economic Costs and Benefits of Alcohol

- 10.1. The National Health Service, Police Authority and communities carry the costs of harmful drinking. The main benefits are to increase the profits associated with excessive drinking to the drinks industry and in taxation to the Government.
- 10.2. Current practices of the drinks industry encourages hazardous drinking, e.g. happy hour, availability of alcohol until very close to closing time, no responsibility for the behaviour or safety of their customers once they have left their premises.