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?

It is justified by virtue of the fact that alcohol is a legal drug from which the Government raises significant revenue.

Where there is a major opportunity for effecting beneficial change through national policies. For example, influencing consumption through altering alcohol taxation policies and restricting availability (use of licensing).

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?

In situations where the effects have a detrimental effect on the individual and they want/need to seek treatment or support, and when adults and children other than the person misusing alcohol are effected (e.g Crime or Human Rights issues).

Whilst individuals should be responsible for their own behaviour, certain individuals need to be protected - eg. juveniles, vulnerable adults, individuals who develop an addiction to alcohol. Forced use of alcohol in a domestic abuse situation would also be a good example of when intervention may be necessary.

However whilst the individual has the right to choose to harm themselves, that should not be at the expense of compromising a safe community environment. Government has a clear role in maintaining such an environment.

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

See previous comment.

This is crucial – particularly in a domestic environment where the health and well being of family and neighbours can be detrimentally affected by problematic drinking. We would argue that this a very difficult balance to strike and that it involves partnership working between agencies (not only health and crime and disorder agencies, but also education, housing, social services, etc) and the provision of ongoing support for those affected by alcohol misuse as well as treatment and support for users.

By looking at the balance of harm or neglect to others (e.g. Child Protection Issues, Domestic Violence or other crime), and the right of the individual to a private life.

Education of the public about responsible drinking and an understanding of alcohol misuse.

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

This is a very broad question. Perhaps this could be considered in terms of groups like the public sector, criminal justice system, commercial sector and the individual. Or ask what's the role of your organisation?

For example, the NHS role could include:

Dissemination of health education messages.
Primary health care role - screening and detection of people with alcohol problems.
Provision of treatment services.
Needs assessment, surveillance, monitoring and public health advice to provide support to local strategic parternship working.

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

Acknowledging that alcohol is an integral part of society today. The social approach taken in the consultation document is to be welcomed.

Realistic aims and claims - accept that societal attitudes change slowly, but government has a huge capacity to speed up the rate of change eg seat belt legislation, drink driving campaigns.

A commitment to take the tough decisions no matter how unpopular for the greater long term good.

Encouraging a healthier attitude towards alcohol in all ages, and a clearly defined, easily accessible support and treatment network for individuals who develop harmful drinking habits. This must include training for all GPs in the recognition and referral of individuals who are misusing alcohol.

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?

For the individual, using alcohol as a coping strategy would be seen as the difference between 'want', which can be decided against, and 'need' which is an urge the individual

has to satisfy.

Individuals perceptions of their own alcohol use. Impact on family members.

For the wider community, alcohol misuse might be anything which leads to antisocial 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?

Patterns to be addressed could include:

The culture of alcohol as a focal point rather than an optional part of celebration or relaxation.

The boasting culture, for example high profile personalities such as Radio One breakfast presenters glamourising binge drinking.

The culture of going out with the objective of becoming drunk; binge drinking (especially amongst young people); the linking of alcohol with stress relief (often portrayed on TV and film - at the least sign of stress, characters are often seen 'reaching for the bottle').

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?

Key group post 16-25 year olds. Expectations of young people have changed - extending childhood as more people stay in education longer, live at home and can support extensive drinking habits with the result being a lack of impetus to adopt more mature drinking patterns. Need to address the culture of idealised heavy drinking.

Key group 30+ age group. The shift to drinking at home with increased availability through supermarkets has made a big impact in this group. Here need to address loss of self management and the awareness that individuals have of their alcohol consumption.

Teenage Pregnancy has identified alcohol use as a particular problem in some unintended pregnancies. Also alcohol plays a role more generally in reducing inhibitions and can be linked to risky sexual activity.

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?

Because of the links between stress and alcohol use, target stressful jobs and careers - perhaps those with long working hours, poor annual leave, unrealistic expectations.

Causes of consumption by young people need to be examined before it can be adequately tackled. Child and domestic abuse survivors (the term survivor, rather than victim is used throughout the feedback to this document) should be also focussed on, alcohol use as a coping strategy in these situations has a particular approach. There is also some evidence to suggest that there are specific ways to work with abusive partners in domestic violence situations where alcohol plays a part. (More detail in 35)

We would argue that there are two other groups where a focus is necessary: victims of domestic abuse and homeless people. Our experience tells us that these issues can be both a contributory factor to and a direct or indirect result of alcohol misuse and that research is essential in these areas. Domestic abuse is mentioned in Q 35 and homelessness in Q 38, but they need more emphasis. We also come across a good many elderly people who misuse alcohol and this seems to be a neglected group.

However a note of caution should be sounded. The key empahsis of the strategy needs to be a societal change of emphasis on the place alcohol occupies in society. Whilst it is important to acknowledge the needs of specific groups, perhaps a few simple clear messages are likely to be more effective in achieving such a broad goal.

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?

Alcohol is a social tool that can facilitate social interation and a sense of community, a focal point such social club. Used responsibly, alcohol is an aid to social interchange, and pubs are a means for people to engage in social activities who may otherwise be socially isolated.

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?

Characteristics of English drinking culture include volume and the amount you can drink, drinking to get intoxicated, deliberate choice of drink to get intoxicated, drinking as a functional tool rather than something to be appreciated and peer pressure across all ages to conform to drinking culture.

The notion that it is admirable or amusing to become drunk. Drinking alcohol is often the purpose of rather than incidental to a night out, especially amongst young people who then brag to their peers about how much alcohol they can drink. Hopefully, for most people this juvenile drinking culture settles into a more responsible pattern, but for some individuals it sets the mould for more long term harmful alcohol misuse.

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?

A very broad question. Whilst we can offer a few comments this question is too broad to offer a meaningful response.

Marketing and fashion is clearly a big factor in introducing young people to alcohol (otherwise why are vast sums spent on advertising drinks with 'youth appeal'?). Peer pressure clearly is linked in with this.

We would add three other factors here: peer group pressure, workplace stress and economic/social exclusion.

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

People don't see themselves as being at risk. Risks are poorly understood and may seem very distant or happen only in extreme cases. Even if people know how many units they are drinking, they are unlikely to understand the consequences of exceeding the guidelines or to consider their risk as significant.

Why would there be a risk associated with anything that is freely available, cheap, legal and heavily marketed?

Risks go beyond the actual use of alcohol to the potential risk taking activity whilst under the influence eg sex, driving.

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

Harmful drinking is that which begins to affect the physical, mental and emotional health or the financial wellbeing of the individual or their family or friends. This may include work issues and legal matters (e.g. criminal activity). Problematic drinking is indicated when planning the next drink becomes the uppermost thought in an individual's mind.

This obsessional pursiut of the next drink leads to deceiptful, surreptitious bhaviour, which is harmful to relationships and work prospects.

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?

Lack of local data on drinking patterns including attitudes and behaviour.

Lack of evidence/research around exact nature of links between domestic violence and alcohol use.

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.

A local report is attached.

Although alcohol does not cause domestic abuse (please refer to answer 35), according to the British Crime Survey Self Completion Module, Mirrlees-Black, 1999 on Domestic Violence, 1/3 of incidents are judged by the survivors to have been committed while the abuser was under the influence of alcohol. Therefore, related health costs do occur as a result of the mental and physical impact of abuse such as, women presenting to A & E for injuries, G.P.visits for old injuries and a variety of illness depression and stress related complaints, treatment for suicide attempts, use of mental health services, miscarriage, survivor use of alcohol support servcies and treatment. It is estimated that the health costs associated with domestic abuse are very high, it was estimated that in 1996 the London Brough of Hackney spent £580,000 on health care costs for survivors of domestic abuse, and this did NOT include the costs of hospitalisation and medication (Stamko et al. Counting the Costs, estimating the impact of domestic violence in the London Borough of Hackney, Crime Concern, London).

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.

Appropriate means are described in the HDA evidence briefing on Prevention and Reduction of Alcohol Misuse, June 2002.

Early intervention through school based awareness and attitude based discussions.

Healthcare professionals should be trained to recognise the symptoms of alcohol misuse, and know how to deal with it sypathetically and effectively. They must realise that it is not a lifestyle the individual has actively chosen, and that it takes a great deal of courage to seek medical assistance. Mechanisms should be in place to professionally support both the individuals and their families, which may well involve specially trained mental health care workers. One to one couselling is more effective then group therapy sessions. It is helpful if the counsellor has some experience of alcohol misuse in order to fully

empathise with the individual's situation.

In relation to domestic violence work, where, as previously stated, survivors can only be adequately worked with if the violence and alcohol issues are simultaeously addressed. Consultation with women survivors generally shows a lack of awareness of domestic abuse by professionals, who need training in awareness and practical issues, such as screening techniques, making appropriate referrals and safety planning.

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?

The HDA report referred to earlier has considerd the effectiveness of brief interventions (p17-18).

As for previous question. I would also add that if the patient was in an abusive situation (as a survivor), it is impossible to successfully work on help and support to reduce alcohol intake if alcohol use is a strategy to cope with the impact or the aftermath of the abuse. For interventions to be successful in these cases, doctors and nurses would have to be trained to routinely screen for domestic violence and to refer to the appropriate services, or facilitate the survivor to devise safety plans.

Need to recognise the difficulties with access and use of health services by men. Promoting access would enable early identification of risk and a potential to reduce long term harm.

The background of the drinking habit is often not fully explored, and the individual will often not volunteer what could be vital information. The problem is likely to be merely hinted at by the individual seeking help (who may be seeking medical help in a half hearted way, to appease concerned relatives or spouse), and so if the doctor does not pick up on the signs and symptoms, the individual is not taken seriously.

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?

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

Alcohol misuse / addiction must be taken as seriously, and treated as formally as drug use. It is a hidden, insidious problem overlooked because it involves a legal substance.

Success in drugs and tobacco is a result of national strategic guidance with attached funding specifically around the key targets. The interventions associated with both drugs and tobacco have been careful to be evidence based.

With the drugs agenda, a multi-agency approach has been essential with efforts to maintain a societal view rather than criminal justice or health focus.

The first step is to acknowledge alcohol as a drug. Parents, adults and young people need to be as concerned about alcohol as they are about drugs. This also provides a tool for comparison.

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?

Short term measures could involve removing those implements used to cause injuries.

Long term measures need to tackle the wider issue of the acceptability of violent behaviour and the changing nature of violent behaviour.

There is a need to identify and understand the issue of aggression whilst under the influence of alcohol - this also cultural issue?

A & E departments should routinely screen women for domestic abuse and refer to specialist services with adequate training, support, policies and procedure in place. This could potentially tackle much of the mis-categorisation of domestic violence assaults as home "accidents".

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?

Individuals may drink because they are depressed, but drinking alcohol can cause depression, and thus a vicious circle is begun. The afflicted individual becomes morose, guilt-stricken and withdrawn, reaching a point of self-loathing which can lead to suicidal thoughts

Survivors of abuse are highly over-represented in both areas of service delivery. There are huge areas of correlation between experiencing domestic abuse and alcohol use/mental health problems. Alcohol and mental health services would have to maintain good links with specialist domestic violence services and provide in-house training for their staff for this overlap to be tackled adequately.

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?

Gaps in exact nature of link between alcohol use and domestic violence (from both survivor and abuser perspectives).

Research/evidence available from National Police Library in Bramshill.Police custody records detail state of intoxification. Youth referral schemes hold information regarding alcohol related offences.Drink/driving offences.Health service records at A& E record injuries but not state of intoxification.

In relation to young people a gap would be understanding their perspective of the issue. Youth and community and young peoples groups experience the results of intoxicated behaviour frequently and there is the potential to gain a wider picture. There are also cultural aspects to this as previously mentioned.

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?

Yes, repeat offenders from anti-social behaviour.Alcoholics, especially those on low income who fund their habit through crime.Particular crimes include domestic violence, theft, shoplifting, violence and anti-social behaviour.Don't know. Limited statistics for one-off offences.

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?

CCTV town centre footage. Custody suites. The need for Pubwatch and Offwatch schemes.Perception levels are fueled by reality. Difficult to measure.

Data gathered locally suggest a higher concentration of recorded nuisance in town centre localities, particularly at weekends.

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?

Staggered licensing hours. Takeaways and other food outlets having extended opening hours in appropriate places.Lighting and CCTV to act as deterrents. Visable police presence.Better transport networks.Multi-agency responsibility.

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?

Larger concentration and variety of premises selling alcohol in urban environments attract livelier, and often younger, client group.Rural areas provide less anonymity with more local community involvement, drinking patterns less erratic and smaller risk of crime being committed due to these factors.

Young people travel out of rural areas to urban areas ie at weekends to clubs and are travelling greater distances.

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?

Alcohol Free Zones and Crystal Clear schemes good practice.Move towards a more continental approach to pubs/bars catering for non alcohol drinking customers.Limiting the number of licenced premises in a particular area.

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?

Yes, a more partnership approach should be adopted, however this does not always work in practice and funding and resource issues are often barriers.

All government departments (including the treasury) need to be actively engaged in supporting implementation of any future strategy.

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

Education is a key to prevention, awareness raising is paramount.

We agree that there should be some emphasis on initiatives serving young people, but not to the exclusion of other age groups.

Domestic abuse occurs every age group.

There needs to be good evidence that anti-social behaviour is caused by young people

before any initiatives are implented. Adults also behavior antisocially and we need to avoid demonising young people. Some perceived anti-social behaviour is actually intolerance from adults.

There is a need to acknowledge that young people are often the victims of alcohol realted crime and antisocial behaviour.

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, staggered drinking hours. A variety of pubs/bars/clubs and a changing attitude towards drinking away from the 'power drinking' culture and 'happy hours'.

We wonder to what extent it is possible to change drinking patterns amongst the economically and socially isolated – particularly where there are also mental health problems. Our experience is that they often cannot afford to drink in pubs and/or have lifestyles so chaotic that drinking at home and/or on the streets, either alone and/or with peer groups may be inevitable without intensive support.

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?

The facility to implement measures are in place, however, the lack of resources to make these effective are missing.

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?

Education on good citizenship backed up by measures to implement enforcement.

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

In 30 years, the drink drive campaigns have turned around public opinion on what was a fairly attitude held by much of society. The combination of a long term (over a generation) public education campaign (with information in many formats - not just posters) with tougher legal sanctions and adequate policing has been highly successful. We need to apply them to any other campaigns (e.g. domestic violence) involving tackling and eventually changing entrenched and harmful social attitudes.

Drink-driving has become unsociable due to the published consequences, especially in relation to the victims and their families. Also the consequences and stigma for the driver have been well argued.Making other alcohol-related crimes as guilt laden and unprofitable is the challenge.

Need to target work around when it is safe to drive after having a drink ie to what extent do people understand how long alcohol can affect a person.

Media portrayal has played a part in changing attitudes to drink driving. Media reporting of drunkeness and drunken behaviour remains ambivalent and yet could play a huge part in changing attitudes.

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?

According to the British Crime Survey Self-Completion section on domestic violence, carried out in 1998, only 1/3 of all violent incidents were carried out (as judged by the survivor) whilst the offender was under the influence of alcohol, suggesting that alcohol may be a factor but cannot be considered a cause as the majority of incidents happened with no such assistance. The research only asked about physical violence and threats, so the impact and discription of any of the emotional, financial or sexual abuse was missing form this survey. There is also no evidence to link the offender's use of alcohol with much of the abusive behaviour. Alcohol use cannot account for the bulk of domestic violence behaviour, the use of power and control on an emotional level, imposing isolation, sexual violence and economic controls. Alcohol use may be an aggravating factor in some assualts, in the U.S. it is estimated that abusive men who drink have a higher level of assaults than those men who do not drink, but the majority of abusive men are not high-level drinkers and most high-level drinkers do not abuse their partners (Strauss & Gelles, 1990). The "alcohol as a disinhibitor" theory is further disproved by the failure of treatment for alcohol in stopping the abuse, abuse continues and can escalate during treatment, thus sometimes putting survivors in more danger than previously. Even in cases where physical abuse decreases, other forms (threats, manipluation, isolation) have been reported to increase, by women with partners in treatment (Minnesota, 1992).Similarly, alcohol cannot be linked with more aggressive changes in the brain, the choice of target and place in all domestic violence situations, and the gender difference would appear to disprove this. The most likely theories are around expectations and social meanings given to alcohol use, it has been suggested that alcohol is often used as time out from responsibilities in life, the subtance can then be blamed for any bad behaviour (this happens generally in alcohol use but could apply to domestic abuse easily). Morley & Mullender (1996) suggest that alcohol is used more as a means of courage to carry out the act, then excuse it after the fact.Thus, any work with abusers who drink to excess would to tackle the abuse (ideally in the form of legal sanctions as a deterrant and in tandem groupwork in line with Respect's Minimum Standards on working with perpetrators) and the alcohol use to be anywhere near successful in addressing both problems.Survivors and alcohol use could actually be more linked than the perpetrators/alcohol. The same British Crime Survey as quoted earlier found that survivors of domestic abuse had far higher levels of alcohol consumption than non-survivors. They also found that risks increase with higher levels of drinking, although they could not deduce whether this was as a cause or consequence. Other studies

cite women who say their alcohol misuse is a direct result of domestic abuse. Drinking as a coping mechanism is well documented amongst survivors, to numb physical or psychological pain or to cope with the fear and manage their daily lives in the face of ongoing abuse, or as escape. Ironically, the very substance a woman uses to cope may actually slow her motor co-ordination, leaving her reactions slower, thus actually stopping her from addressing her safety needs or reacting protectively at times. Alcohol use can increase a survivor's vulnerability to threats and coercion, threats to "out" use can be used to control (especially as women who drink are at greater risk of losing residency of any children), treatment can be sabotaged. Abused women who drink are less likely to be believed, more often blamed for the offender's behaviour and cases are more often seen as "half a dozen of one, half a dozen of the other". Refuges cannot always accept heavy drinkers, due to lack of resources, few spaces for women with complex needs or lack of staff trained. Alcohol services may not identify or deal with signs of domestic abuse, therefore leaving issues of safety unchecked.With any treatment for surviors to be successful, as with perpetratos, the dual isses of violence and alcohol use need addressing simultaneously, for e.g. relapse prevention and safety plans need to exist co currently.Good Practice: The gendered nature of domestic abuse has to be acknowledged, in that between 81 and 99% of survivors are women (depending on the survey/research), this has a bearing on service delivery, for e.g. the necessary existance of women only services/workers. Some Women's Aid or outreach projects will provide support for women with substance use and violence issues, or work directly with substance misuse services in some way. Some good practice has started in Tower Hamlets where a time limited post has been created to look at the links/gaps between both service areas. Nottinghamshire have a Women's Substance Misuse team whose role is to work with women survivors who are experiencing abuse and using substances. Alcohol East are also developing intervention in the form of a Women, Domestic Violence Substance Misuse Worker to provide counselling, brief intervention, advice, advocacy and support to women who have developed substance misuse problems due to a previous/current violent relationship and to women experiencing substance misuse related domestic violence in Newham, Tower Hamlets and Redbridge. In addition this post will deliver training to local professionals to raise their awareness in relation to Substance Misuse and Domestic Violence.

Local experience, based on police interview records, estimate that, approximately 63% of offenders and 35% of victims had consumed alcohol prior to an incident taking place. Whilst these figures are not conclusive it is generally felt that alcohol is an aggravating factor in domestic abuse and can exacerbate an already hostile and potentially violent situation. Indeed, the most violent assaults have a strong association with alcohol and/or drug abuse.Victims and offenders can also be known to have drug/alcohol problems.Good practice could include better recording systems of the interrelationship, and drug services putting alcohol/drug misuse and its relationship with domestic abuse firmly on their agenda.

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 poor family support, and with a family history of alcohol misuse. Also those who have limited life choices. Situations where parents misuse alcohol to the extent where it prevents them from looking after their children adequately (i.e. in cases of neglect). Or children and young people who are being abused. Also, children may take on a role as young carer.

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

Domestic abuse survivors, especially where the abuse is still happening or the impact is still having an effect on them. We would identify older, single people as being at risk and vulnerable. Also homeless and young people.

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?

Key factors are child abuse and domestic violence. Understanding the effects and impact of these on people is crucial to tackling any of the above named problems, for e.g. in research carried out by The Children's Society, occasional runaways were 7x and repeat runaways 17x more likely to say they had been hit a lot by their parents. Over 80% of all runaways cite family problems as influencing their decision to leave home, which will include family conflict of all kinds and alcohol use. There are well documented links between abuse, substance use, depression and a whole host of mental health problems.

Interventions would have to be long term and take into account all the problems to be successful, especially interventions designed to tackle situations where family abuse exists.

The issue of the link between homelessness and problematic alcohol use is not necessarily about street homelessness. In our Borough, we have no recorded street homelessness, but there is a less visible problem in that demand for rented housing is high, empty RSL property levels are low, private rented accommodation is scarce and property prices in the owner occupied sector are relatively buoyant. We deal with around 400 homeless applications per year in a small, prosperous, semi-rural northern Borough and commonly find that applicants have multiple problems, including alcohol misuse, even where their homelessness does not make them roofless.

We consider that support for this group is the intervention required – both to prevent homelessness in the first place and to ensure tenancies don't fail once the homeless person is housed. Help with lifeskills such as budgeting, benefits advice and debt management, obtaining furniture and decorating materials, referral to health, social, educational and other support agencies, etc. can mean the difference between a tenancy succeeding and failing. It can break the cycle of alcohol dependence and homelessness and ensure that a homeless person is not permanently excluded from housing because of his or her history of alcohol related anti-social behaviour and debt.

We would also like to highlight the link here between mental health (particularly depression and anxiety) and alcohol abuse. Even where treatment is available and where clients choose to use it, scarce resources mean that the support which should accompany it is patchy.

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?

Joining up of services can only happen if frontline staff from all the agencies are able and encouraged to build good relationships with others in other agencies, given adequate training on all of the client's complex needs, backed up by senoir management in the form of policy and procedure. The development of shared protocols and understandings as a long term goal could contribute to this, although this usually needs a long time to develop, especially where agencies have very differnet aims and remits. Workers' lack of time can inhibit this, as can dislike of institutional change at all organisational levels. See Q35 for joined up delivery examples.Joined up services, in the area of domestic abuse and substance misuse, there is very little, refuges and substance misuse projects often work together. Also see initiatives in Q35.

Methods for allocating funding sometimes lead to weakening of partnerships as agencies (particularly in the voluntary sector) are forced to bid against one another for "pots" of money to keep their projects viable. The Drug Action Group in our Borough works well

together and has made progress on inter-agency partnerships but we do sometimes find ourselves in competition for scarce resources, which can force agencies or sectors to "close ranks" in order to protect their own interests.

We also feel that joined up working seems to hit a brick wall when scarce resources mean there is insufficient treatment available. Unless treatment of the appropriate type is available when the client needs and is ready to accept it, the agencies offering support are put under unreasonable pressure, which can stress partnerships with treatment agencies.

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-bycase basis? What is your experience?

My experience is that the complex needs of domestic abuse survivors are left mostly unaddressed, and not dealt with adequately at the moment. I think, ideally, there needs to be a mixture of funding for specialist services but also awareness and practical skills that are developed by mainstream agency staff through training.

Can/will the local strategic partnerships and community strategies aid this joining up?

Teenage Pregnancy has clearly outlined the part alcohol can play in unintended pregnancies along with the impact alcohol has on sexual activity. The new Sexual Health campaign is focusing its efforts on pubs/clubs, colleges and social venues.

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?

All of the above.

Any information giving must be linked to the capacity for individuals to do something immediate in response to the information. Valuable lessons can be learned from the HEA tobacco campaigns.

There are a range of objectives including:
Establishing the health risks.
Challenging thinking of the place alcohol has within society.

Thinking of alcohol as part of drug culture.

Alcohol use does have a specific culture due to its legal status. Whilst we need to outline the links with drugs we also need to maintain specific impetus around the differing nature and perspectives of alcohol use.

Successful examples include the HEA's smoking Testamonials campaign.

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?

Behaviour change is a complex process which can be difficult to measure however precursors such as attitudinal change are easier to measure and more attributable to health education interventions. This point applies both retrospectively when looking for examples of good practice and prospectively when setting success criteria.

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?

Is this information being directly collected nationally? Current data from national surveys, such as the Health Survey for England, currently only provides proxy indicators for the second and third parts of this question. Current meassages are not clear and have lacked consistency. Confusion has arisen through changing messages. A parallel can be drawn with physical activity where eight years after the most significant change in recommendations there is still uncertainty amongst healthcare professionals (let alone the public) about physical activity recommendations.

Individuals may know the effects of their drinking behaviour- eg. leading to short term risk taking behaviour, the potential for long term harm if they drink heavily - but the accepted culture makes it difficult for them to change their 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?

The HDA's prevention and reduction strategy briefing has been a useful addition but alcohol lacks the supportive infrastructre that drugs and tobacco benefit from for dissemination and implementation.

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)?

If the objective is to shift the population norms around attitudes to alcohol then there is a need to adopt whole population approaches. Whilst specific groups might be targeted within the overall strategy, we should remember that 90% of the population drink alcohol. Individuals do not exist within a social vacuum and need to be considered

within wider family and social networks which night be missed within a narrowly defined approach.

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?

Educational instutions should have alcohol frameworks or policies incorporating educational components, access to services, guidance for staff, links to employment practice and should cover students, staff and visitors.

Services should link clearly with other such policies in school ie SRE and PHSE programmes, national healthy schools standards.

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 evidence that families are key in establishing young peoples drinking patterns but to be able to positively influence this the points made in Q43 need to be addressed (clear, consistent meassages).

Local experience suggests parents of teenagers welcome support and advice as to how best to engage young people in discussing all aspects of substance use. However, to roll out such programmes carries clear resource implications.

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?

Government has a clear role in leading culture change and challenging cultural norms on alcohol and its place in society.

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

Initiatives with an abstinence message are ineffective.

Harm reduction has been well validated and is a realistic target.

Initiatives are most effectice where there is multi-agency involvement.

Additional resources with national targets provide clear focus for action.

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

Advertisements for alcopops and similar sweet alcoholic beverages are still clearly aimed at young people and are strongly image focused. The voluntary advertising code and self

regulation works does not appear to be effective. It is in the manufacturer's interest to recruit new drinkers.

Is it appropriate for a drug that causes so much harm to be advertised at all? Tobacco advertising has recently been banned, should we now be turning to 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?

The targeting of young people by the drinks industry is a conscious effort by the trade and is manifested by new product ranges of sweet, high alcohol content drinks many based around popular childhood soft drinks.

There appears to be a growing trend for fashionable wine bars and clubs which promote a 'lifestyle'.

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

Such market led solutions are most likely to add to the problem, as the marketing machinery will remain ahead of the harm reduction strategy without some measure of control.

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?

Voluntary codes proved ineffective with the tobacco companies. Would this be any different for the drinks industry?

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?

We are concerned that this question needs to be asked. Local data is poor but we are sure that this is available nationally, previously having been collated by the HEA.

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?

As for Q56.

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?

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?

Unsure of the evidence for this.

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