

**MEETING OF PARTNER AGENCIES TO DISCUSS THE NATIONAL  
ALCOHOL HARM REDUCTION STRATEGY IN EXETER, DEVON**

**HELD ON 12<sup>th</sup> DECEMBER 2002**

**PRESENT**

**Peter Taylor, Exeter Drugs Project**  
**Elaine Ashworth, Exeter Drugs Project (Teignbridge Drugs Project)**  
**Carol Stephenson, Exeter Drugs Project (Prison Services Manager)**  
**Kristian Tomblin, Drug Action Team**  
**Jeff Pearce, Partnership Sergeant, Torridge Police Station**  
**Danny Caldwell, Torridge Police Station**  
**Karen Mead, East Devon District Licensing, Exmouth Police Station**  
**Michael Miller, Exeter Community Safety Partnership**  
**Mel Lovell, North Devon Community Action**  
**Frankie Robinson, North Devon Community Action**  
**Neil McDonald, East Devon Licensing Officer, Exmouth Police Station**  
**Peter Kelly, Exeter Licensing Officer**  
**Charlotte Coker, Devon & Cornwall Probation Service**  
**Colin Harrison, Addaction (Alcohol Arrest Referral, Exeter)**  
**Sarah Mitchell, Addaction (Devon Alcohol Intervention Service)**  
**Martin Honour, Addaction (Residential Services)**  
**Mary Greener, Addaction (Exeter HQ)**  
**David Axon, ENDAS**

**APOLOGIES**

**Rachel Littlewood**  
**Peter Phillips, Progress to Work**  
**Chief Supt. Liam McGrath**  
**Spt. Marsden, Paignton Police**  
**Sonia Blake, Exeter PCT**  
**Kathy Moran, Connexions**  
**Lucy Rutter, Exmouth Youth Service**  
**Lynn Brookes, Addaction (Devon Probation Partnership)**

**This meeting was called in order to bring together as many individuals and agencies as possible in order to co-ordinate a response to the National Alcohol Harm Reduction Strategy consultation document. It is acknowledged that many agencies, individuals and other multi-agency groups are responding to this document separately. This meeting was for anyone who wished to take part in a broad multi-agency discussion about the document and formulate a joint response.**

**As the document is sub-divided into eight areas of interest and asks a total of 61 questions, we split up into four groups, each group looking at two areas each**

and answering the questions pertaining to those areas. It was agreed that the notes would be written up and circulated quickly and any changes or amendments be forwarded to Mary Greener before Christmas. Any changes will then be incorporated into a second draft which would again be sanctioned by all those who attended the meeting before being sent to the Strategy Unit as a response to the consultation document.

Mary's contact details are:

[m.greener@addaction.org.uk](mailto:m.greener@addaction.org.uk)

59, Magdalen Street, Exeter EX2 4HY. Tel: 01392 255151/285904.

## SECTION ONE

### THE PRINCIPLES THAT SHOULD UNDERPIN THE STRATEGY

1. Why should the Government get involved in managing the harmful effects of alcohol misuse?  
*There is a fine balance to be achieved between protecting the rights of the individual to engage in a legal activity. However, we feel that intervention is appropriate when the negative effects of alcohol use outweigh the positives and there is a resulting negative effect on the individual, the family and the broader community.*
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?  
*Intervention is appropriate when drinking begins to control the drinker, rather than the other way round, particularly if others are adversely affected through crime, health costs, environmental damage etc.*
3. How can we strike a balance between individual and community rights and choices?  
*As above: the costs to communities can be significant as well as the waste of potential and poor quality of life. Safe environments for drinking should be encouraged and monitored so that it can be pleasant for those drinking and does not have a negative affect on those around them.*
4. What are the respective roles and responsibilities of consumers, voluntary groups, commercial interests and others?  
*All have responsibilities to provide and share resources for enjoyment and do what they can to ensure that problematic drinking is discouraged.*
5. What principles should underpin a national alcohol harm reduction strategy?
  - *Proper resources and ownership*
  - *Recognition of cultural differences*
  - *Clear objectives need to be set*
  - *Long-term objectives, not quick fixes*
  - *Individual rights should be upheld as far as possible*
  - *Clear definitions are necessary, eg harmful, misuse etc*

- *Definitions should be agreed*
- *Mixed messages need to be challenged*
- *Clarity and consistency are vital*
- *Strategy MUST be multi-agency*

## SECTION TWO

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

6. **How do you define alcohol misuse? What factors do you take into account?**  
*Alcohol use is misuse when it adversely affects the individual, the community and the economy. Need to take into account health, mental well-being, legal issues, family, anti-social behaviour, age, gender and culture.*
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?**  
*Safe drinking levels (units) can be used as a baseline for change. Binge drinking can be dangerous to health and lead to anti-social behaviour, especially at weekends. Young people should be targeted regarding binge drinking. Drinkers who regularly drink over safe units but are still able to function normally can, with support learn how to drink safely. Drink driving initiatives are largely successful because it is not perceived as acceptable to drink and drive. The drinks industry sends powerful messages to young people, eg it is ok/cool to be drunk. The industry should be more heavily legislated, as should advertising. Prevention initiatives should be focused on young people.*
8. **Is there a relationship between trends in drinking and wider social changes – eg 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?**  
*Need to make being drunk less attractive without making it difficult for people to admit to having a problem and seeking help. Some workplaces may consider alcohol testing. It may be useful to think about a complete ban on driving after drinking.*
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?**  
*Families containing heavy drinking parent(s), need services to support family. Services for parents with teenagers with drink/drug problems. Support for families as a result of drink-related domestic violence.*

- 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 an acceptable and welcome feature of celebrations, social gatherings etc and can help some people feel more at ease. If it weren't for alcohol, other substances may be used.*

- 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 age groups?**

*It seems part of the English drinking culture to binge drink in order to get drunk. Some pubs seem totally geared up to heavy drinking and some are not child-friendly. We need to try to separate drinking culture from “yob” culture as the two are often put together and may not necessarily reflect reality. Few coffee bars open in the evening, so it is difficult to find social meeting places not centred around alcohol. In areas of the north where beer is cheap it is bound to lead to heavier drinking.*

- 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?**

*Family background, peer pressure, fashion, availability of alcohol and other drugs, children who have a parent with an alcohol problem, reactive factors – eg alcopops introduced to boost sales of alcohol to young people which had slumped with the introduction of ecstasy. More disposable income.*

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

*Low self-esteem, poor coping mechanisms, lack of confidence, social exclusion, poor achiever, depression may affect attitudes to risk taking. Also, some people don't worry about the effects on their health of heavy drinking. People who don't have much self-respect may not think about the consequences of heavy drinking but drink to feel better.*

### **SECTION THREE**

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

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

*When used inappropriately, eg high volume; dependence, damage/harm to others eg health & relationships.*

- 15. How clear is the evidence both for the health costs and the health benefits of alcohol? Are there key pieces of research of which we should be aware? Where are the gaps in the evidence?**

*There are conflicting messages, eg too much alcohol will harm you/ some alcohol can help protect your health. Generally drinking in moderation is seen to be acceptable and “healthy”. More credible research needed over longer period of time. 3 billion pounds spent within NHS on Hospital services related to alcohol – don’t know enough about other costs, eg on Primary Care and specialist community services.*

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

*See above. Also “Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals – Royal College of Physicians, London 2002.*

- 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?**

*Education and early intervention, training based on knowledge and experience, counselling, good assessment skills and consulting users about their views.*

- 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? Important that GPs are properly trained to do this and that they are clear as to when they need to refer on. They can work if professionally delivered but they don’t work for everyone, especially those with entrenched drinking patterns and several other problems.**

- 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?**

*Current treatments work for some people and should be tailored to individual needs, although this is patchy and probably more flexible in the voluntary sector. We would want to encourage commissioners to think more about aftercare services, more effective care pathways and easier routes into rehab. Need earlier interventions and need to address advertising.*

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

*Better use of role models, peer education, asking young people the best way to inform them and make heavy drinking less attractive*

21 & 22 Not answered by group.

#### SECTION FOUR

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

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

*Statistics are available from Police, Probation, Home Office, Primary Care, Hospital Services and Provider Agencies, although these have to be interpreted carefully. There is no strategic pathway for the routing of direct evidence. Lots of anecdotal evidence.*

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 – especially violent crime including domestic violence, criminal damage, drink-driving, disorder. One-offs can be “flashpoints” leading to violent acts and out of character drink-driving. Generally alcohol related crime is not pre-meditated (unlike drug-related crime) and is often forgotten by the perpetrator.*

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

*Via statistical evidence, especially looking at the timing of incidents, ie coinciding with pubs closing.*

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?

*Late night food outlets as congregation points, location of taxi ranks, licensing hours, homelessness. Multi-agency responsibility, needs multi-agency/community/strategic response.*

27. How does the impact of alcohol on urban environments differ from its impact on rural environments? What are the differences between urban and rural drinking patterns and how do they affect those communities and surroundings?

*Problems tend to be concentrated in certain points in urban settings. More hidden in rural communities and tends to be more tolerated. More drink driving in rural areas, lack of police presence. But drinkers probably less*

*likely to cause trouble in rural areas as they will risk losing access to the pub and will have no others to visit.*

- 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?**

*Drinks industry largely against plastic glasses because of cost. Initiatives such as in Cardiff are good, having bottle bans in the street and in some towns and cities total drink bans in the street. Planning applications can be influenced so that we do not have clusters of pubs/taxis/parks/food outlets forming ghettos.*

- 29. There are some examples of good practice where a range of organisations responsible for dealing with different aspects of alcohol have successfully combined efforts and shared information to tackle alcohol-related crime and disorder together. Should this approach be encouraged more widely? What inhibits organisations or communities from taking such an approach?**

*Yes – via Community Safety Partnerships including licensing forums. There are difficulties about data protection. Lack of a strategy and finance inhibits the progress of such initiatives which work well for drugs and could be transferred to alcohol.*

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

*Yes, but not exclusively and this needs to be balanced with the industry approach which targets young people. Need to create good education programmes concentrating on prevention and harm reduction and encourage looking at family issues around drinking. Peer pressure also a significant issue.*

- 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?**

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

- 32. How can the law on, and policing approaches to public drunkenness and street drinking help to tackle these problems? Are existing controls and powers (such as those for local authorities to introduce no drinking zones) effective? Are they sufficient?**

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

- 33. One person's good evening out can be another person's sleepless night. Are there principles to guide the balance of individual rights and responsibilities?**

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

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

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

- 35. Domestic violence is often associated with alcohol misuse – either by the perpetrator, or, on occasion, by the victim. What in your experience is the nature of this link and what would you see as good practice in tackling the interrelationship between domestic violence and alcohol misuse?**

*Helpful interventions via domestic violence specialists in police and probation, links to women's refuges, anger management groups, reactive not preventive, this could improve. There is a county-wide domestic violence strategy but not everyone aware of it. Sure Start could contribute to family support initiatives. Sometimes agencies don't make the link between domestic violence and alcohol misuse.*

## **SECTION FIVE**

### **THE IMPLICATIONS FOR VULNERABLE GROUPS**

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

*Potentially any – it would be a mistake to assume that any would be exempt. Those more prone to peer pressure, those who are less well supervised, those who may have a parent or two parents who drink heavily, especially if domestic violence takes place.*

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

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

- 38. Those who are vulnerable to the consequences of alcohol misuse often have complex problems (for example they may be homeless and may have additional mental health or drugs problems) and such factors may be inter-related. What key factors need to be understood in addition to alcohol use that contribute to maintaining the problems facing such groups? Which of these factors should interventions be aimed at?**

*Social exclusion, unemployment, inadequate housing, poverty, no access to leisure or learning. Interventions need to be based on a menu of tailored items, possibly part of structured day programmes with a holistic approach and including groupwork components aimed at raising self-esteem etc. Also need to consider the opening hours of services to make them as accessible as possible for those who are trying to get back to work and possibly influence the business community to produce alcohol in the workplace policies giving people agreed time off to attend services.*

- 39. How can the services provided by the state and others to vulnerable groups with complex problems be joined-up most effectively? Are there examples of joined-up delivery it would be helpful for us to be aware of? What gets in the way of joining-up services?**

*Joint initiatives do exist, especially in the criminal justice field, ie Prolific Offender Units, DTTO schemes, Arrest Referral and many of these are monitored or influenced by Community Safety Partnerships. In some areas Priority Action Teams exist and take on alcohol. All of this is patchy and varies depending on the political will and the ability to make cash available. One obstacle to joined-up working can be a clash of ideologies among different agencies, ie regarding harm minimisation and abstinence.*

- 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?**

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

## **SECTION SIX**

### **EDUCATION AND COMMUNICATION**

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

*To give clear, concise and consistent messages which are realistic and delivered in an appropriate way.*

- 42. Given clear objectives, what is the evidence on the effectiveness of these approaches? What do they actually achieve? How can their effectiveness be measured?**

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

43. **How well is the sensible drinking message reaching its audience? Is it sufficiently clear? What is the evidence on its penetration and its effect on behaviour?**  
*Messages about units do not seem to be getting through – variation in interpreting what a unit is and some examples of people “saving up” their units and binge drinking.*
  
44. **How well is scientific research feeding into alcohol education? Is the message based on sound, unbiased and uncontroversial research and are new findings effectively incorporated?**  
*This is not working – young people especially will dismiss it and not relate it to themselves. Information about consequential behaviour and harm is more relevant.*
  
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 (eg elderly drinkers)?**  
*Targeting generally perceived to be unhelpful – need to give clear messages about the harm associated with alcohol use universally, although it may be of use to stress the dangers of lone drinking for elderly people.*
  
46. **What is the role of schools, colleges, universities and other educational institutions in providing alcohol education as well as support for alcohol-related problems? How can we best establish and preserve a healthy learning environment?**  
*Must be built in to community/life studies and stress harm to health and communities. Peer education initiatives useful.*
  
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 and families are role models for children and the way they behave will have more impact than what they say. Joint educational initiatives, informing parents and children together will ensure consistency and could be offered through schools.*
  
48. **What does experience show on the most effective means of getting messages across? Are there circumstances in which the Government is particularly well placed to do so, or conversely might be particularly unsuccessful?**

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

- 49. What can we learn from educational initiatives in the field of illegal drugs?**  
*Don't use the “just say no” approach or hysterical scare tactics. Aianput from former addicts is effective and a measured, unemotional description of the harm done at many levels.*
- 50. Do you have views on the existing regulation of advertising on alcohol?**  
*Needs to stop making out that all drinking is positive and makes you a more attractive person. Health warnings could be issued as with cigarettes.*

## **SECTION SEVEN**

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

- 51. Do you have any thoughts on the likely evolution of the alcohol industry over the next decade?**  
*The consumption of alcohol likely to increase. Media pushing young people to party with alcohol, making bottles and labels more attractive and less harmful. Alcohol content levels seem to be increasing in lots of products.*
- 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?**  
*Need to be truthful and make links between current trends and uses/misuses of particular types of alcohol, eg “vodka and red bull gives you energy”. Increasing use of “happy hour” leading to binge drinking; lots of supermarket offers, “buy one get one free”*
- 53. How far do you foresee research and development creating innovative market-led solutions to the problems of alcohol misuse?**  
*Possible creation of “magic pill” to sober up immediately and not lead to problems such as drink-driving, domestic violence etc. Would have significant impact on crime and disorder but such a solution could introduce other health risks.*
- 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?**  
*Joint education initiatives with the industry about safe and enjoyable drinking levels, warnings on bottles and adverts etc.*

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

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

## **SECTION EIGHT**

### **THE ECONOMIC COSTS AND BENEFITS OF ALCOHOL**

**There was no time to discuss this section.**

**Peter Phillips from Return to Work could not attend the session but asked us to point out that there is virtually nothing in the document about getting people back to work following difficulties with alcohol.**

**END – 13<sup>th</sup> DECEMBER 2002**