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Response to Consultation Document

On

National Alcohol Harm Reduction Strategy

1. We felt that targets should include a). focus on changing the culture in this country and b). aim to assist those who are addicted into recovery.
2. *Introduction* : In 3rd last sentence we felt that the list of key organisations should include 'probation'. It was also our opinion that this part of the document would benefit from reference to the need to learn from what works research – effective interventions should inform practice.
3. *What do we want to know ?* : Under section iv we felt that you could add (to vulnerable groups) those who already suffer from poor health, e.g. those with liver damage. We also felt that there should be specific reference to children not only as potential (a)users of alcohol but also as children of current alcohol abusers.
4. *The principles that should underpin the strategy* : In question 1 we felt the reason why the Govt. should get involved are basically the same as the rationale for involvement in drug misuse or is the pressure from the alcohol industry a disincentive ? It is clear that the rationale for involvement emanates from the cost of alcohol related crime, the costs to the NHS, the costs to industry of lost 'sick' days. Q.2 Alcohol misuse ceases to become an individual responsibility when its misuse affects other people, when it incurs cost for NHS, increases risk in the workplace, when lives are lost, when children are exposed to its abuse (often in their own parents, and in the effect on increased insurance cover). Q.5 The principles that should underpin a strategy should include: equal access to treatment, harm minimisation, education, prevention and citizenship, the involvement of users wherever possible. Is the pressure from the alcohol industry a disincentive ?
5. *The cultural and behavioural issues around alcohol use and misuse* : Q.6 Alcohol misuse can be defined as any use which has a social, physical, mental impact on and individual's well-being. Q7 Drinking patterns which need to be addressed (in the strategy) include 'binge-drinking', violent behaviour (spec. Domestic violence and street violence), drink driving, daily over-consumption. Q.8. The answer is obviously YES. The focus for influencing behaviour should be on educating media to their share of responsibility. 'Soaps' through to 'Adverts' all sell the use of alcohol in positive terms, the young are particularly susceptible

to these messages. Q.9 Too often we operate by stereotypes, in this country we are familiar with the immediate connection between drinking and the Irish. Provision needs to be set up to address need in ethnic groups. Q.10 We thought this was a false question. The strategy is aimed at harm reduction not prohibition ! Q.11. We felt that there was such a thing as an 'English' drinking culture. It differs markedly from our European neighbours. Its about 'going out to get drunk', binge drinking. One group that needs especial attention are the children of abusing (alcohol) parents. The factors influencing behaviour (in Q.12) that we identified were the media and in particular advertising, family therapy work, parenting, peer group pressure, physical and genetic susceptibility. The attitudes to risks (Q.13) affected by the dis-inhibiting use of alcohol for us include :- sexual behaviour (teenage pregnancy, sexual disease), drink-driving. Those who have ADHT are recognised to be more likely to take risks. We also feel that there is a danger in this question of failing to recognise that Risk is not necessarily a negative, it can be and often is a positive feature of life. Encouraging positive risk-taking (e.g. sail training, extreme sports or Duke of Edinburgh awards) may decrease harmful risk taking.

6. *Health : prevention, treatment and the impact on the NHS* : Harmful drinking (Q14) can be described as consistent abuse of a recognised healthy level of (unit) alcohol intake. We did not feel that the evidence for the benefits of alcohol (Q15) were clear, in fact they could be contradictory, e.g. red wine leading to breast cancer but reducing cardio-vascular disease ! Q.16 would be better directed at the NHS dept. to which presumably there is access by government departments! The means to prevention of alcohol dependence (Q.17) are through Alcohol Education Groups (possibly accredited in due course ?), treatment for users and ensure that this not carried out in isolation from significant others, peer support groups, A.A. In our experience 'brief interventions' (Q.18) are effective. There is experience of this with offenders in Probation circles. We felt that a successful approach could be based in CJS of diversion / caution allied to contracts to carry out brief intervention with recognised agencies. It was also felt that G.P.s have a potentially significant role in reinforcing positive health messages as and when they come across problematic drinking patterns – sometimes the voice of authority may make the difference in the cycle of change. Q.19 re effectiveness of current treatments requires consultation with users. Lack of funding is a real factor in this area. We have much to learn from drug prevention and treatment (Q.20), alcohol is a drug of choice so no real difference. It should also be recognised that in coping with drug abuse alcohol is often used as a (next day) coping mechanism. On the Isle of Wight there is a pattern of chaotic use of substances (cock-tailing) which may also be a rural pattern and reflects difficulty in getting drug of choice. Minimising and preventing injuries (Q.21) could be achieved through more use of plastic glasses, bottles etc. We also need to look at creating policies for alcohol in the work-place, policies in school (sending children home when they are intoxicated could be dangerous). Health professionals also have a role in picking up on injuries which result from alcohol abuse. There is a real connection with mental health problems (Q.22) particularly

around 'dual diagnosis'. Close alignment of services is required and inter-agency teams.

7. *Crime, disorder and anti-social behaviour: the effects on our surroundings and community* : Q.23 the introduction of assessment tools for offenders such as OASys and ASSET will provide rich data on links between alcohol and crime. The crimes most affected by alcohol abuse (Q.24) are Domestic Violence, Street violence, Shoplifting. The difference between perception and reality (Q.25) in crime is a false one, perceptions are important as is recognised in the governments targets on reducing fear of crime indicates. If you feel threatened you are. Factors which influence alcohol related anti social behaviour (Q.26) include lack of social activities, lack of staggered closing times. It is our opinion that we should be encouraging different drinking patterns. We also need to understand better local drinking patterns, the more we do the better the strategy. Public drunkenness can be controlled through bye-laws. Where domestic violence and alcohol (Q.35) are concerned there is a real connection but one is not causal of the other. Sequencing work is important and resources should be targeted accordingly.
8. *The implications for vulnerable groups* : Those most vulnerable (Q.36) include those with low self esteem, those children living with alcohol dependant parents, looked after children, those outside the school system, young offenders. Other groups (Q.37) include the elderly, stress related occupations, isolated. The key factors (Q.38) include peer group pressure, homelessness, boredom. The services provided by the state (Q.39) can be more effective if they are need driven rather than politically driven (influenced by alcohol industry).
9. *Education and Communication* : Successful examples of what works (Q.41) include 'interest by others', 'drink diaries', 'contracts'. Sensible drinking messages (Q.43) are not getting through to the public. We need greater use of units as a medium. Alcohol sold in bottles and cans should contain unit information. The public need to have a greater understanding of how their behaviour alters according to unit consumption and use the information to control their behaviour and use of alcohol. Scientific research (Q.44) is not used well. For example there is evidence that consumption of vitamin B reduces alcohol appetites, is this used ? Q.45 young people should be targeted for information and communication. Parents have an important role (Q.47) in education, e.g. non-association of alcohol use with stress etc. Q.50 alcohol advertising should include information about units. Again, messages from peer groups will influence behaviour. They can encourage drinking, or they can discourage/prevent (i.e. AA groups).
10. *The shape of the market and market based solutions* : Q.51 the evolution of the alcohol industry looks destined to continue targeting young people, e.g. through alco-pops etc. A positive move forward (Q.54) may be to encourage the alcohol industry to diversify more into non-alcoholic drink, after all there is as much profit there as there is in alcohol !

11. *Economic costs and benefits of alcohol* : Is any of this information available from different government departments or the NHS (e.g. cost to industry of lost work days) ? If not, such research should be funded and used to underpin the strategy. Such research should be **independent** of the drinks industry.

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