National Alcohol Harm Reduction Strategy
Consultation Document

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Salford Drug Action Team welcomes the draft strategy. It has considered the consultation document at the DAT meeting on 9 January 2003 and is pleased to provide the attached response.

Our comments are grouped under the 8 major themes listed in the consultation document as opposed to a specific response to all 61 questions.

Various partners including DAT officers, the PCT, Alcohol Services and the Community Safety Unit have contributed to this response.

We have attempted to express a consensus viewpoint, whilst recognising that in relation to a number of the questions raised there may be some variation in personal views.

Background

Salford developed an Alcohol Strategy in July 1994. This was based upon a comprehensive needs assessment incorporating epidemiological, professional and lay perspectives. The Strategy was agreed by the Health Authority, FHSA and Social Services and its implementation brought about radical shifts in the commissioning and delivery of alcohol services within the city. Specific developments included the availability of brief interventions within primary care settings, the general hospital emergency department, criminal justice system, an alcohol / mental health liaison service and a home detoxification service. Changes introduced were reviewed through an outcome funding methodology which facilitated monitoring the effectiveness of new or re-investments.

More recently it has become apparent that in comparison with drug services, the development of alcohol services locally and nationally is inhibited by the absence of a national strategy to define a framework for service developments and associated dedicated funding to effect such developments.

Whilst recognising that a national strategy would eventually emerge it was considered important to undertake work locally on the modernisation of the existing Salford Alcohol Strategy. This work has involved the PCT, Community Safety Unit, DAT and Salford Alcohol Service and has resulted in a local alcohol strategy which has now been endorsed by the DAT and CDRP. It is agreed that in order to move forward there is a need to create an Alcohol Coordinator post and to integrate this within the DAT structures. We are currently exploring sources of potential funding for such a post. Our local experience indicates that alcohol services require the same strategic focus as drug services.

1 The principles that should underpin the strategy (questions 1 – 5)

Government are already substantially involved in managing the harmful effects of alcohol misuse by virtue of its responsibility for treatment (via the NHS), education (via Education) and crime and disorder (via the Police and other partners). It also receives considerable revenue from taxation of alcohol.

We feel that there are particular responsibilities in terms of ensuring primary prevention activity (ie education for young people and parents), secondary prevention activity (for problematic drinkers) and to work towards safer communities by encouraging 'safe city' schemes and working with retailers. Transport policies are a particular area where improvements could be made.

There is a responsibility to ensure responsible advertising and marketing and we remain concerned about the promotion of flavoured alcoholic beverages (alco pops) to young people, notwithstanding the advertising code of practice.

We are not convinced that the move towards liberalising licensing hours (ie possible 24 hour licensing) will result in a reduction of alcohol related harm.

2 The cultural and behavioural issues around alcohol use and misuse (questions 6 – 13)

There are a number of useful definitions which can be employed, a simple one being "if it is causing problems for you or anyone else". However people do not fall into one type of behaviour or another but may move between various patterns of drinking

Categories of hazardous, harmful, dependent drinking are useful as are the use of safe / sensible limits.

A national strategy should focus around the hazardous, harmful, dependent definitions used by the WHO and should incorporate recognition of the value of brief interventions.

Prevention efforts should concentrate upon young people and public information eg campaigns and unit labelling. Advertising practice, including the association with sport and other healthy activities should be reconsidered.

Wider social changes include the increased independence and autonomy of women and it is felt that there has been a trend towards similarities in drinking behaviours between men and women.

Increased disposable income within certain groups has also had an influence on patterns of consumption. The relative cost of alcohol appears to have decreased and the trend towards more home drinking encourages higher consumption. Attention needs to be focused around younger, single and professional people.

There are various groups of people where for various reasons the level of alcohol consumption may be concealed until the problem becomes sufficiently serious to present with health and social problems. These groups may include elderly people, pregnant or women trying to conceive, people with mental health problems and people from black and minority ethnic communities.

The use of alcohol assists social behaviour and personal relaxation and in limited quantities can have certain medicinal or health benefits. Our culture would be affected in terms of its use and availability at social events, celebrations, and the disappearance of the pub culture.

English drinking culture has changed rapidly over the recent years with regard to town and city centre volume drinking of younger people. Pubs which tend to have an older clientele are in decline and drinking at home is now a well-established part of our culture. The drink-driving campaigns over recent years have undoubtedly played a part in changed drinking habits. From the perspective of the North West we are aware that there are historical connections with heavy industry and are aware that the decline of these industries in some communities has resulted in increased substance misuse.

We feel that peer and family influence are very significant but also disposable income and cost of alcohol are powerful forces. Advertising and brand associations may be more important factors in relation to younger people and areas where influence could be brought to bear by government. We are aware of the substantial investment made by brewers in advertising campaigns, and are aware of the impact of other advertising campaigns affecting behaviour, eg drink driving, HIV/AIDS.

Some people will respond to messages about risk and there are particular high risk areas, eg mixing alcohol and medication drugs, drink driving, unprotected sex.

3 Health: prevention, treatment and the impact on the NHS (questions 14 to 22)

A simple, standardised screening tool is needed eg AUDIT to define harmful drinking.

We should recognise the impact of social harm eg effect on relationships and employment or violent aggressive behaviour, as well as physical and psychological harm.

It is known there are high levels of harmful drinking in the North West and in Salford particularly (*Health Survey for England*).

A key piece of research is *Alcohol consumption and mortality: modelling risks for men and women at different ages* (Ian R White, Dan R Altmann and Kiran Nanchahal) BMJ 2002; 325:191.

Clear health messages are needed –

- The impact of any alcohol consumption varies with age and pattern of drinking.
- Binge drinking is harmful even if the weekly rate is not exceeded.
- Increased alcohol intake is associated with higher mortality.
- Greatest benefit is to men in the older age group but the risk of excessive drinking outweighs any potential benefit. Therefore drinking should not be encouraged as a protective response in groups who normally do not drink alcohol.
- There is no health benefit to drinking alcohol in the younger age group.

The cost to the NHS:

- The role of the government is in conflict by benefiting directly from tax obtained in the sale of alcohol whilst at the same time indirectly costing the NHS, Local Authorities, police and probation services resources to manage the adverse consequences of harmful drinking.

- The impact of alcohol in injuries and falls at all ages (alcohol may have been implicated in 2/3 of fatal falls in women over 65 years of age [Bell *et al* 2002] and in St Mary's 1/3 of women who have falls are drinking excessively). The young age group are at greatest risk of road traffic injuries.

Prevention of misuse and dependence:

- Screening and appropriate levels of information, education or counselling - adequate training of professionals to screen and counsel alcohol use.
- All staff should be trained to obtain accurate drinking history and not just 'social drinking' as adequate quantification.
- Pro-actively seek the influence of alcohol injuries
- Access to information and support via Emergency Departments where major and minor injuries as a result of alcohol consumption present to health services.
- Signposting of support groups should be available at all statutory agencies.

Drugs prevention and treatment activity is endorsed by the availability of a national strategy, a commitment of funding and the requirement to deliver outcomes in these areas. It is unlikely that comparable activity with regard to alcohol can be delivered until there is a properly resourced national alcohol strategy.

As a disinhibitor alcohol can be a factor in suicides; as a drug with a depressant effect on the nervous system it can be closely associated with depression. Developing better links and understandings between alcohol and mental health services would help.

4 Crime, disorder and anti-social behaviour: the effects on our surroundings and community (questions 23 to 35)

The increase in the availability of 'safer' drinking places in town and city centres will obviously reduce 'glassing' incidents, however, drinking from bottles remains very popular, particularly with people who do wish to monitor their alcohol intake. With regard to young women it is said that bottles can be popular as a means of preventing drinks being tampered with.

The experience in the inner City of Manchester of its city safe scheme has highlighted these links and also provided evidence of constructive responses and management of these issues. It would be helpful to have prevalence information around trouble hot spots.

Addressing public transport issues has reduced incidents around taxi ranks.

It is important to inhibit the development of inner city ghettos of young people drinking in a harmful manner. We need to engage local pubs/clubs/off licenses to take responsibility for the behaviour of their customers if they contribute to hazardous drinking habits eg happy hour, extended licensing, need for crowd control and the protection of young people from violent, aggressive behaviour, confiscation of glasses and bottles returning to the streets.

Town planning should ensure all drinking establishments are not placed in one area but dispersed and mixed with venues which bring a range of people whose aim isn't purely to drink alcohol.

5 The implications for vulnerable groups (questions 36 to 40)

Young People's Substance Misuse Plans identify those young people who will be more vulnerable to substance misuse. In addition to these we should also recognise that young people with a high disposable income could also be vulnerable.

In addition to the other vulnerable groups suggested, it may also be helpful to consider other high risk groups eg publicans, chefs, doctors, police etc.

As with people who develop problems around drug misuse we are aware of other socio-economic factors, poverty, family background, social exclusion, lack of education, coping strategies, which can contribute to problems which individuals can experience with alcohol.

The delivery of services based within primary care settings and one-stop shops would enhance accessibility. ‘Joined up’ services rely heavily on the corporate commitment of partners and the need to recognise the gains that would result within their particular constituency of interest.

Mainstream services have a crucial role to play in providing advice, information and referring on to specialist services.

6 Education and communication (questions 41 – 50)

We are not convinced that the sensible drinking message is reaching its audience if we are to believe the evidence around increased per capita consumption amongst most, if not all, social groups.

Access to education or support may be more difficult in religions and cultures where alcohol abstention is the norm eg Hindus, Muslims and Sikhs and the pressure to hide problematic drinking is great.

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. Support mechanisms for parents and schools to tackle alcohol consumption is essential.

Literacy may be a barrier to obtaining information or seeking support.

Education and information should be comprehensive and targeted at different levels and different groups.

Need for examples to be set by key statutory agencies such as health services, local government, education, police and probation service to ensure consistent messages are delivered about hazardous drinking.

Human Resources Policy on alcohol is needed for all statutory agencies. Alcohol consumption at work, even during lunch times, should be discouraged and support provided for those seeking or requiring help to combat hazardous drinking. Alternatives to alcohol should be provided at social events.

Advertising should be prohibited near schools or before the watershed

Lack of teacher training around the delivery of drug and alcohol education and relative lack of priority within the curriculum.

Need to ensure quality education is delivery around skills and attitudes and to address peer pressure to participate in consumption of alcohol.

High levels of alcohol misuse amongst young people correlated with youth crime and anti-social behaviour are also a significant factor in the high rate of teenage pregnancy within Salford.

The response to smoking in terms of banning television advertising and emphasising the health dangers is one example of a campaign which has had an impact.

Manufacturers of alcohol are driven by profit motives and advertisers will always argue that they are responding to what consumers want and there is a great irony over the role of the Portman Group acting on behalf of manufacturers. There needs to be an independent watchdog. The code of practice with regard to advertising is particularly weak. It has recently been proposed that manufacturers disclose their research to reveal if they are targeting young people.

7 The shape of the market and market-based solutions (questions 51 – 55)

Without radical intervention current developments are likely to continue, ie liberalisation of licensing laws, increased segregation of our drinking culture, town and city centres offering 24 hour drinking availability, increase in home consumption, decline of the local pubs and development of the super / sports / club / pubs.

Similarly trends towards producing higher a.b.v. products (strong lagers and ciders, stronger wines) is likely to continue thus maintaining the trend towards higher per capita unit consumption.

Alcoholic drinks should be adequately labelled in terms of units and recognise that measuring one unit of alcohol varies depending of the country of origin.

It would appear that the marketing of imitation alcohol-free or low a.b.v. products has been a comparative failure.

The government's working with the alcohol industry is likely to remain fraught given the revenues which are realised from alcohol taxation.

One of the main commercial interests associated with alcohol is sport and this remains an anachronism.

8 The economic costs and benefits of alcohol (questions 56 – 61)

The economic costs to the health service and the criminal justice systems are much clearer than the benefits.

There would be benefits in promoting national guidance in relation to 'alcohol at work' issues which should include clarity of expectation and employers

‘duty of care’ responsibilities. It should not be promoted in terms of reducing stress and tension and facilitating networking in the workplace. There is evidence from drink-driving that even moderate amounts of alcohol can impair judgement.

Focus on promoting non-hazardous drinking behaviour.

If health service and police carry indirect costs of alcohol consumption then the drinks industry should be taxed / fined where their practices encourage hazardous drinking.