

Replied via email 30/1/03

SUFFOLK
DRUG ACTION
TEAM

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Our Ref: CNG/BJB

9 January 2003

SU/DoH Consultation
Room 4.6
Admiralty Arch
The Mall
London SW1A 2WH

Dear Sir

**SUFFOLK DRUG ACTION TEAM - RESPONSE TO NATIONAL ALCOHOL
HARM REDUCTION STRATEGY (Consultation Document)**

Please find attached the above. If you wish further information or clarification please contact me.

Yours sincerely

B. Barrance

P.F.

Carey Godfrey
DAT Co-ordinator

The Drug Action Team (DAT) is made up of:

* Chairperson (Chairperson) - Chair Executive - Suffolk County Council - Carey Godfrey - DAT Co-ordinator

Other members include representatives from:

* Social Care Services * Suffolk Constabulary * Suffolk Probation Service * East Anglia Orchestral * HM Customs & Excise * HM Prison * SAVU * District/Schools Councils * Suffolk Health

“National Alcohol Harm Reduction Strategy”

Response to Consultation Document

General

1. This is not a strategy, it is at best an attempt at posing a set of possible agenda setting questions.
2. The document contains no when, why, what, how statements and makes no reference to possible scope of any future action, or resources that may be available.
3. The document is far too wide; there are no priorities set and no indication given of how they may be set.
4. The document makes invalidated assumptions that most of us drink sensibly but certain groups may be at risk: such assumptions make any possible programme of public awareness difficult as it is implied most citizens do not need one.
5. There are no basic planks of hard information: no mention of units.
6. A tighter framework would be helpful, reference to Mental Health NSF for example; four key points/milestones could be set.
 - Mental health
 - Family/community/domestic violence
 - Access to treatment
 - A change in public attitude (viz drink driving)
7. Basic principles lacking, e.g:-
 - Employers responsibilities
 - Expenditure of NHS (and other) funds could be reduced
 - Prevention
 - Learn from cultures within England which do not drink
 - Community responsibility

Greater emphasis needed on:-

- Co-morbidity
- Self harm/suicide (of ‘Drug Related Deaths’)
- Child protection issues
- Different environments (rural, large conurbations etc)

- Review of current funding streams
- Expenditure of public funds on those who drink sensibly as well as those who do not.

Detailed response by paragraph

1. Intervention is needed; alcohol is a harmful substance and there is significant evidence of ill effects in society at large.
2. If individual behaviour harms others, costs tax payers money, then intervention is justified.
3. Wider education to achieve a balanced relationship between society and alcohol.
4. To promote a healthy drinking culture at all levels of society.
5. Challenge to present cultural attitudes:-
 - Public acceptance that alcohol is a harmful drug – whatever the pattern of use (c.f. cigarettes, passive smoking etc).
 - Same approach to alcohol as to other drugs; it is least as harmful and considerably more costly to society.
6. Some examples are when it is used as a coping device or as self medication.
7. One challenge should be to binge drinking and young people.
8. Focus on influencing behaviour: if youth then around fashion, advertising; a culture of student drinking.
9. Middle aged and elderly, professional women, those with mental health problems.
10. This is not a strategy for prohibition.
11. Young people have a fun perception. Certain cultures do not drink. Within cultures individuals have problems (e.g. self-medication, mental health etc).
12. "Youth Culture" promotes heavy drinking (e.g. Cox and Moyles on Radio One). Drugs are bad, alcohol, even excessive consumption, is not.
13. The demonisation of drugs and the normalisation of alcohol, means there is less perception of risk across society as a whole. (A view

re-enforced in a most unhelpful way in the Foreword of this document).

14. This should be addressed the other way round; people do not drink for health reasons, they drink to get drunk. Could also look at triggers to drinking.
15. The cost purely to the NHS, far outweighs any benefits – there are no health benefits worth considering. Alcohol is not marketed or advertised as a healthy product.
16. Direct costs in A&E etc; indirect costs also need examining; social care, criminal justice etc.
17. Training for GPs – the NTA is proposing a triage access to drug services with a Tier One assessment by a vast range of non specialists, a similar approach is needed here.
- 18 & 19. Go for high profile treatment services who cater initially for the motivated who self refer. Look at triggers. Develop a Care Programme approach. Alcohol is not illegal. The Criminal Justice legislation should concern itself with alcohol crime, not this strategy.
20.
 - A tiered approach.
 - Wide access to treatment.
 - Free thinking away from legal/illegal.
 - Tiers of training.
21. Public awareness.
22. Tiered approach, CCA and CPA; a linked set of interventions. Of paramount importance is training for mental health staff to increase confidence and competence in dealing with drinkers.
26. Amongst other factors are environment and transport, particularly in rural areas.
27. This is complex. However, alcohol consumption by young people may lead to vandalism, unsafe sex etc in rural areas, whereas in an urban environment there is an increase in violence as people come together etc.
28. The 1999 Alcohol Concern document promoted the mandatory use of plastic containers. Personal licences for licensees would ensure greater responsibility. Promotion of supportive/coping strategies; "look after your friends", "avoid potential risky situations" etc.
29. The Strategy should encourage local partnerships that initiate relevant local initiatives and responses.

30. No, why only young people? Better to target positive coping strategies etc. An Alcohol Strategy should leave crime to Criminal Justice legislation.
31. Promote a community and group attitude (look after others etc) very successful with drink driving. Promote unacceptability of public drunkenness, irrespective of crime (c.f. attitudes in Spain and Italy where it is a social disgrace to be seen drunk).
32. The effect of criminalising does not tackle alcohol abuse (and may be counter to seeking/providing help).
33. Yes, my behaviour in public should not offend others – this is what governs civilised society.
34. Encourage the 'socially acceptable' mode of behaviour. Encourage look after yourself and others; plan ahead, think the evening through etc. Learn from drink driving.
35. Tackle the violence as just that; separate it from alcohol to get away from the muddled "he was just drunk" justifications. Then provide a high level of alcohol treatment.
36. Young people and children are all vulnerable – there is violence, abuse and neglect in all classes of society. Young people in care or with mental health problems have particular needs as do those who find themselves cast as a young carer.

There may be issues for young people from minority groups (including travellers, cultural minorities etc) as the services their elders receive may fall outside the mainstream.

37. Everyone who drinks will have at some time been at risk etc etc. Particular attention needs to be paid to co-morbidity issues, those in areas where services are poor, those in high risk professions such as seamen, doctors and journalists.
38. Alcohol interventions should be aimed at reducing intake and/or a chaotic pattern of intake. However, the triggers are relevant. It is important to remember that individuals acquire an addiction, which has to be dealt with as such, irrespective of having any other issues.
39. Opposing agendas may prevent joined-up solution. For example, Probation deals with crime and has to meet national standards to do with crime, yet a high percentage of their clients have serious alcohol problems. There is an increasing number of funding

streams emanating from the centre, all with own priorities – which often prevent joined-up working.

40. Alcohol services should be for people with alcohol problems. It may be that locally partnerships between CDRPs and PCTs may prove helpful, particularly if a reduction in NHS costs can be one outcome. The language of "vulnerable groups" is a way of separating people out – why do this? Make mainstream services more flexible and acceptable for all.
42. Information on safe drinking and units etc do not translate from theory to practice in the eyes of the general public.
43. Usually ignored; people drink to get drunk, not to be safe. Strategies should address coping with intoxication, not how to count units.
44. Why does it have to? What is this strategy to be for? Those who drink know what the effects are; we need to be able to deal with these and provide coping mechanisms to allow individuals to do so.
45. Parents and twenty somethings. Provide a sufficient level of education so drinkers can all self diagnose and seek treatment.
46. Schools etc are workplaces so start with the staff – their own drinking and attitudes. Highlight the responsibility of governors etc. Then teach coping strategies rather than sensible drinking etc. Schools may not be the best place to provide education (see the success of information/education on teenage pregnancy).
47. Peer education is effective. Licensing laws place a barrier between children and adults. Children learn by family example only to a limited extent.
48. Do not demonise alcohol -- accept it and be honest.
49. Not much as they could hardly be considered successful.
50. If it must be advertised it may be helpful to separate it from lifestyle messages: attitudes may change if the association between alcohol and power, success and sex are broken.
51. Growth!?
52. In a capitalist society the relationship is all important; this is what drives all marketing and advertising. However, many drink from depression and loneliness etc; it is not only lifestyle. The trend to consume until totally out of control has become normalised for young people, i.e. (universities, Club 18-30 and football etc). this lifestyle link should be broken.

53. Not at all; there has been misuse of alcohol for as long as there has been alcohol. Changes in society's approach, make drunkenness unacceptable and demeaning; teach children about self worth not about "fun".
55. Sponsorship must affect consumption.
56. What are the benefits of alcohol? Plenty of cultures function without it and plenty have been destroyed by it. Let's work in the here and now and offer treatment and help to those who need it.
58. Most "sensible" drinkers have at some time generated a cost. Encourage responsible employers and workplaces (including schools, government departments etc).
59. Tax revenue and employment: the maths should be done to balance this against costs. Also the profits go to a small number of individuals not to society as a whole.
61. The Royal Mail has set a good example.

In Conclusion

Those currently in need should be helped now. More treatment services need greater levels of training for all front line staff. A timetable for implementation is required urgently – front line services cannot continue to wait.

This document has been produced after consultation in Norfolk and Suffolk amongst specialist agencies, police, social care services, young peoples services etc etc.

Penny McVeigh
10 December 2002