

National Alcohol Harm Reduction Strategy

Consultation Document

Response of the Dudley Substance Misuse Task Group

Q1. Why should the Government get involved in managing the harmful effects of alcohol misuse? At what point does Government intervention become justified?

A. Government has five main functions in preventing and managing alcohol misuse

- Balancing the rights and liberties of different sections of the community e.g. the right to relax and enjoy noisy parties vs the right to an undisturbed nights sleep
- Influencing the conditions of trade in alcohol so that all costs of producing, selling and consuming alcohol including the external costs are born by the producers, sellers and consumers.
- Influencing the degree of “wetness” of society so that the benefits to society of alcohol consumption exceed the costs to society.
- Ensuring that people have the information of alcohol content of drinks and consequences of different drinking behaviours so that they can make informed choices.
- Ensuring availability of appropriate treatment and rehabilitation services to help those who have suffered the consequences of alcohol misuse are whose drinking behaviour places them at risk of suffering such consequences.
- The Government needs to judge how much harm it wishes to reduce.
- National strategy, direction, inter-departmental working and resourcing are key aspects to Government involvement.

Q2. 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?

A. Government intervention should be centred on protecting the individual, whether a family member, alcohol user or innocent individual, from potential harmful effects.

To ensure that individuals are aware of alcohol being a drug and the need to respect use and the harm of misuse.

Q3. How can we strike a balance between individual and community rights and choices?

A. The Government needs to represent that which society may deem to be responsible and reasonable; to also use legislation and education to deliver a balanced position.

Q4. What are the respective roles and responsibilities of consumers, voluntary groups, commercial interests and others?

A. To lobby and influence Government in coming to a reasonable stance.

Q5. What principles should underpin a national alcohol harm reduction strategy?

A. 5.1 A national alcohol strategy needs to cover three issues:

- Prevention of drinking patterns that lead to harmful consequences. (This includes prevention of heavy drinking).

- Encourage for those with harmful or risky drinking patterns to change to less risky patterns. (Usually this means drinking less)
- Treatment programme for those who have suffered harm as a result of their drinking

5.2 To take account of the principles and elements of the Alcohol Concern document “An Alcohol Strategy for England”.

5.3 To have an agreed definition of harm.

Q6. How do you define alcohol misuse? What factors do you take into account?

A. The strategy needs to be concerned with all types of drinking that has harmful consequences, both for the drinker and others.

Q7. What drinking patterns should an alcohol harm strategy seek to affect? How susceptible are such patterns to change? Where should the Government concentrate its efforts to prevention?

A. 7.1 Three inter-related characteristics of drinking patterns are associated with harm:

- Binge drinking (drinking large amounts in a short period of time)
- High weekly average consumption
- Drinking in inappropriate contexts (driving, work etc)

7.2 Government needs to pay attention to all three but the context of drinking will probably prove least difficult to influence and binge drinking most difficult to influence.

Q8. 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?

A. 8.1 Culture changes to occur but it is difficult to direct these changes. In particular we need to ensure that we are not encouraging a culture of heavy drinking (e.g. 24 hour 7 day city). Advertising of alcohol and leisure products needs to be monitored to ensure is not encouraging undesirable cultural change. Official bodies need to be careful that they are not giving out conflicting messages by inappropriately lavish provision of drinks at entertainments.

8.2 Positive trend such as relaxing with the family, leisurely drinking with leisurely meals need to be encouraged.

8.3 It must be remembered that most heavy drinkers become lighter drinkers as they get older. A major aim of policy must be to support and encourage this “natural” process. Care must be taken to associate the switch to lighter drinking with desirable consequences such as ability to do other enjoyable things.

8.4 While alcohol problems are by no means exclusively associated with deprivation in many situations harmful drinking and deprivation co-exist. Deprivation and social exclusion typically have elements of lack of money, lack of employment and economic opportunities, poor quality housing, lower quality neighbourhood, environment, increased risk of being a victim of crime, poor education and high frequency of relationship problems. Heavy drinking may feature in this web of deprivation as casual factor exacerbating other

problems and as a “drug of solace” being one of the few available pleasures in a drab existence. It is important that the many Government initiatives intended to tackle social exclusion and deprivation take account of the part played by drinking since other measures to improve quality of life may be thwarted if harmful drinking by individuals in communities is not addressed.

8.5 Research based responses are required. Children, young people and adults with family responsibilities should figure in focussed action.

Q9. 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?

A. Young males and young females should be the subject of special consideration, the latter in regard to teenage pregnancy and sexual behaviour.

Q10. 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?

A. Alcohol is so intimately linked with many social and cultural activities that it is difficult to disentangle the consequences of drinking and non-drinking aspects of the activity. There is increasing evidence that building social capital (increasing quantity and quality of social interaction, and mutual trust and support) is good for the health of communities and individuals. The communities that grow up around local pubs and societies undoubtedly contribute to social capital. Shared drinking with friends provides a context in which social capital is built. It should be noted that in all these instances increased social capital comes from the interaction rather than from the drinking but it is debateable whether the interaction would occur without the drinking. Where alcohol is consumed in conditions, which do not encourage social interaction none of these benefits accrue.

Q11. Is there such a thing as 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?

A. Yes – there is a culture of young persons binge drinking, with consequent impact on children. Also drinking without food and not as part of a meal.

Q12. 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. Influential factors on behaviour include culture, environment, religious and personal beliefs, parenting, education, life experiences and price mechanism.

Q13. How do attitudes to risk affect use of alcohol?

A. 13.1 Heavy drinking, smoking illicit drug uses are all examples of risk behaviours. Those with a tendency towards risk taking might be more likely to engage in them. There are many recorded cases characterised by polydrug use. Equally there are anecdotes of young people regarding alcohol as deeply uncool while recreational drugs are cool. It is very difficult to predict the extent to which changes in use of alcohol would effect changes in use of other substances.

- 13.2 The theory that less problematic drugs are acting as gateways for more problematic drugs has some evidence to support it but is certainly an over simplification of many situations.

Prevention and Treatment

Q14. How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become problematic drinking?

- A. Whether drinking is harmful depends on the context and the quantity.

The relationship between quantity and harm has been extensively debated. Any guidance on quantity is necessarily arbitrary. However some guidance is necessary and it is important that it should be consistent from all sources, and viewed as reasonably compatible with most lifestyles. The guidance doesn't drink more the 4 units (3 for women) in any one session is not viewed as compatible with many peoples idea of a reasonable night out. The guidance don't drink more than 21/14 units per week was viewed as restrictive but just about compatible with a reasonable enjoyable lifestyle. We need to refocus these messages in a way that does not invite another crop of "experts got it wrong", "Government changes its mind" type headlines.

Q15. How clear is the evidence both for health costs and health benefits of alcohol? Are there key pieces of research of which we should be aware? What are the gaps in the evidence?

- A. 15.1 Health costs due to alcohol may be caused through intoxication, chronic heavy consumption or dependency. Health consequences of intoxication are injuries (especially head injuries). In extreme cases intoxication may lead to acute alcohol poisoning with coma and even death. Health consequences of chronic heavy intake are numerous including disease of liver, peripheral nerves, muscle, cerebellum, central nervous system, pancreas, stomach, small intestine etc. These are not seriously questioned though there is considerable debate over the precise dose response and factors, which may modify the risk associated with any particular level of consumption. It is also clear that the risk of harm due to chronic heavy intake depend not only on the total consumption but also on the pattern of intake. In most cases drinking in binges is associated with greater risk than consuming in smaller more frequent amounts.
- 15.2 The benefits of alcohol consumption tend to relate to regulated intake; such benefits may be outweighed by costs either financial or non-financial !.

Q16. What are the costs of the NHS both directly and indirectly due to alcohol?

- A. Reference is made to the detailed work of the centre for Health Economics at York University, particularly that of Christine Godfrey.

Q17. 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?

- A. Prevention within current education and family service situations, the workplace and the mass media opportunities should be crafted and resourced.

Brief interventions are reported to be the most cost-effective approach in regard to misusers, across the range of agencies. Training of staff within agencies could provide for significant intervention opportunities, if encouraged and monitored.

Q18. 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 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?

- A.
- 18.1 Brief interventions have undoubtedly been shown to be effective. However further information is needed on what exactly constitutes a brief intervention. Is it a five minute interview or a series of three thirty minute interviews? What are the essential elements in a brief intervention? What settings (A&E, primary care, pharmacy, dental surgery, alcohol agency) are most appropriate. Who delivers the intervention more effectively (GP, practice nurse, counsellor, etc). Who delivers the intervention most cost effectively? These questions need to be answered but are not reasons for not introducing brief interventions now. Methods can be improved as knowledge becomes available.
- 18.2 Despite the proven effectiveness GPs have proved reluctant to offer brief interventions. This probably reflects both the pressure of other work and also the lack of confidence of many GPs to engage with alcohol problems. Repeated exhortation have not changed the situation markedly and it would probably be better to seek solutions providing increased support to GPs such as developing cooperation between local alcohol agencies and practices and enhancing the role of practice nurses.
- 18.3 A development, which may well prove valuable, is provision of intervention over the internet. Current examples are undoubtedly crude and unlikely to be effective but future developments may produce highly effective interventions. This approach is likely to be very cost effective.

Q19. Do current treatment for alcohol dependence and hazardous drinking work? Are there 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?

- A
- 19.1 There are a wide range of treatment programmes ranging from very expensive in-patient/residential to less expensive home based low contact. There is evidence that most treatment programmes do help some people. It is also probable that different people do better in different programmes although it is very difficult to predict who will do well in which programme.
- 19.2 Various principles are clear:
- We need a wide range of different services
 - We need a mix of public and voluntary sector service providers
 - The current level of provision needs to be increased
 - No one method of intervention is clearly better than any other
 - Brief interventions especially those offered through general health services have a useful part to play
 - Home or community based interventions are in general cheaper and therefore more cost effective than residential ones. However there is still a need for residential services for certain clients
 - Generic services (hospital, primary care, social services, probation, police, prison) need to be encouraged to engage with clients who have drinking problems but they need to have easy access to specialist alcohol workers to support them in this.
 - AA play a vital role in supporting many people with former or current drinking problems. While they operate outside normal service

governance they should be encouraged and supported where this is acceptable to them.

- There is a need to cover a broad range of service requirements for those who are excluded both health and social wise and those within the Criminal Justice System.
- To ensure that adequate financial and other resources are available to support the development of required initiatives and to underpin current good practice working which may be vulnerable to broader resource pressures on agencies.
- That all services are integrated and working together through effective partnership arrangements.
- That all services are appropriate for the supply of interventions at each tier of a model of service (as with the four tiers within the model of care for drugs).
- That the Criminal Justice System is effectively a part of the whole response for commissioners and service providers to act on a true partnership basis.

19.3 There is concern that the present target driven culture of the NHS and the public service militates against adequate provision for alcohol. Because alcohol does not feature in the list of priorities for star ratings or chief executive deliverables it is all too easily forgotten. The solution to this is not too add yet another target for alcohol to the already long list but to encourage service providers to make proper assessment of local health priorities and allocate their resources accordingly. Ring fencing of funding for drug services may further distort the local pattern of services. Funding for drug services is very welcome but rapid expansion of drug services has sometimes drawn skilled personnel from alcohol services. Provision of alcohol and drug services need to be planned together so that neither develops at the expense of the other.

19.4 There are perceived areas of under-provision or gaps in regard to current services, some of which need to be developed and underpinned with recurrent resources, e.g.

- Primary care - early identification/access and interventions.
- Older people within the community.
- Control of advertising and subsequent responsibility for this.
- Development of parents' understanding of their influence and responsibilities on their children in regard to alcohol consumption.
- Similarly, parental insight into the impact of domestic violence, perhaps fuelled by alcohol consumption and the possibility of such violence being an example that their children will follow in adulthood.
- Alcohol in the workplace policies and opportunities for advice and intervention arrangements should be a requirement, just as the Health Promoting Schools initiative is within Education.
- Criminal Justice System - the 'captive' nature of clients should be seen as a timely opportunity for assessment, assistance and pre-release and post-release support. This is inadequate in regard to drug misuse and virtually non-existent in regard to alcohol misuse.

Q20. What can we learn from drugs prevention and treatment?

A. Dudley is piloting an Alcohol Arrest Referral Scheme against the background of a Drug Arrest Referral Service. This is funded by the Treasury and is being independently evaluated. It is expected to be a learning experience to inform on future provision.

Drug Treatment and Testing Orders may also be a route to consider in regard to alcohol.

Legislation and dedicated funding of resources will be vital to success.

Q21. 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?

- A. Research experiences elsewhere in regards to change in key areas of activity e.g. licensing conditions, use of plastic drinking glasses and bottles, interventions in A&E departments, alcohol and the workplace initiatives.

There is the need to take account of important issues of alcohol use and domestic violence child abuse and teenage pregnancy.

Q22. 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?

- A. No comment.

Q23. What evidence is there about the links between alcohol and crime and the links between alcohol and anti-social behaviour? Are there key studies and pieces of evidence you think we should be aware of? Where are the gaps in the evidence?

- A. Dudley Community Safety Audit reported 33% of all recorded offences as being alcohol related.

There needs to be a improved method of recording the relationship between alcohol and crime. There is a need for specific criteria and data.

Q24. 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?

- A. 24.1 Alcohol is particularly likely to be involved in offending by older offenders who are repeatedly convicted of relatively minor offences. Again it is difficult to unravel causality but heavy drinking is clearly involved along with repeat offending in the life pattern. It is probably simplistic to suggest that if the alcohol issues were addressed there would be no further offending, but solutions, which do not include alcohol among the issue faced, are unlikely to be effective. It might be said of these offenders that alcohol is one of the factors that stops them growing out of crime.
- 24.2 Arrest referral schemes show some promise as an intervention to reduce re offending. Not only do they divert the offender from court saving valuable police and judicial time but they offer the offender an opportunity of change at a time when he or she (usually he) may be particularly motivated to pursue the opportunity.

Q25. 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 the accurate?

- A. 25.1 There is a strong association between crime (especially violent crime) and heavy drinking. This is mostly an association between intoxication and crime. People may be quicker to engage in violence when intoxicated. The financial demand of heavy drinking may motivate people towards acquisitive crime. Some of the association may be artifactual in that intoxication may make

criminals easier to detect and apprehend. Also pubs may be a convenient meeting place for planning crime and alcohol may be used for Dutch courage.

25.2 The association between alcohol and public disorder is well recognised. Individuals may be more willing to challenge authority when intoxicated. Where a large group have been drinking it is likely that the behaviour of each group member will be reinforced by the others.

25.3 The effect of alcohol on lowering inhibitions is well known and associated with disorderly behaviour and sexual activity.

Q26. 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 may be involved? How easy are these factors to influence? Who is responsible for them?

A. Influencing factors with regards to crime and disorder, include:

- Licensing hours
- Transport home
- Availability of food – as a prominent feature within an establishment
- Close proximity of licensed premises
- Policing profile and capacity
- Law and enforcement
- Partnership working between agencies
- Peer and family influences

Q27. 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?

A. No comment.

Q28. 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?

A. 28.1 Proper management of the drinking environment has an important part to play in minimising harm due to alcohol. Measures to increase server responsibility may help. There should be full use of powers under licensing law to challenge licensing of premises associated with trouble. Premise managers should be encouraged to require proper behaviour by their customers. Local initiatives to develop skills of bar staff and door staff should be encouraged. The law on not selling to people who are intoxicated should be enforced.

28.2 There is a particular problem with off license premises. Police should make it their business to know where public order offenders buy their drink and discuss the problem with owners of premises.

28.3 Planning decisions and regulation of retail activity need to be sure that they do not encourage problematic drinking. In particular decisions involving the creation of 24 hour drinking zones and large concentrations of drinking venues need to be carefully considered.

28.4 The document "Secure by Design" by Dudley MBC has been nationally

recognised as good guidance to contribute to community safety.

28.5 There should be input from a "Crime Reduction Officer" to each planning application.

Q29. There are some examples of good practice where a range of organisations responsible for dealing with different aspects of alcohol have successful combined efforts and shared information to tackle alcohol related crime and disorder together. Should this approach be encouraged more widely? What inhibits organisations and communities from taking such an approach?

A. There is undoubtedly the need, for example, for crime and disorder reduction partnerships to establish the facility for a "data warehouse".

Company objectives of agencies can impede overall progress, for example, performance targets for court appearance inhibiting assessment, brief intervention and report on clients where alcohol has been a factor in crime or misbehaviour.

Q30. Is it right that anti crime and anti social behaviour initiatives need to be targeted on young people?

A. Yes

Q31. 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?

A. Encouragement of different drinking patterns needs to be research based.

Q32. 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 efficient?

A. There is the need for the Courts and the Police to have access to agency services that first access and then address the often complex needs of repeat offenders – to try to tackle the root causes.

Q33. 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?

A. No comment

Q34. Drink drive policies are generally acknowledged to have been successful. What can we learn from them?

A. While enforcement can be shown to work, it is recommended that a researched approach be taken; evaluate initiatives for drink-driving, arrest referral and workplace.

Q35. 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 the link and what would you see as good practice in tackling the interrelationships between domestic violence and alcohol misuse?

A. Key factors are the reduction of inhibitions due to alcohol and an underlying personality propensity to violent behaviour.

Good practices need to be identified and relayed, with the expectation of adoption.

The needs of victims should be adequately addressed.

Q36. Which children and young people do you see as being most vulnerable to the consequences of alcohol misuse?

- A
- 36.1 There is good evidence that most young people drink. They start drinking well before age 18. A few drink heavily. Some drink with families while others drink alone or with friends. Given that appropriate use of alcohol is a learned behaviour it could be argued that it is desirable for children to learn to drink in the company of responsible adults and good role models. Concern over children's drinking needs to be concentrated on drinking away from adult company and drinking excessive amounts. It is unrealistic to expect children to drink nothing until the legal age and then suddenly start drinking reasonably.
- 36.2 The problem of under age drinking needs to be considered. It is accepted that it is often difficult for a proprietor to assess the age of younger people. Great emphasis has been laid on the use of proof of age cards. These have the problem of appearing to put requirements on younger people that do not apply to older. These difficulties could be reduced by removing the emphasis on alcohol and linking age related privileges and restrictions. Thus lower age not only implies lack of permission to purchase alcohol and cigarettes, but also right to obtain cheaper tickets for travel and various facilities. Linking these might make use of proof of age cards more acceptable.
- 36.3 Youth offending teams report a link between alcohol and offending behaviour. It is important to recognise that alcohol like any other substance is chosen often for its effect. A young person can learn to drink responsibly, however there are times when young people feel that alcohol provides the answer and the depressant properties are actively sought so they no longer have to face up to the responsibilities of everyday and young people have become physically dependant on alcohol and experienced withdrawals, The negative impacts such as attending school, work and developing and maintaining family relationships. It is important to recognise the link between sexual health and alcohol, young peoples first experience of sex is often after drinking.
- 36.4 Child protection issues related to alcohol use also deserve consideration. Parents who are intoxicated may be unable to ensure the safety and well being of their children. Alcohol related domestic violence may further place children at risk.
- 36.5 Children's services play an important part in reducing the risk that they engage in harmful drinking. They do this not by attempting to focus on alcohol as an issue but by providing a framework of interesting ways to engage with society and thus reducing the competing attractiveness of getting ones thrills from alcohol.

Q37. What other groups would you identify as particularly at risk and vulnerable to the harmful effects of alcohol?

- A.
- Young people who are part of a night-time/early hours culture of drinking and aggressive behaviour.
 - Similarly in regard to some attenders of large gatherings e.g. sporting events.
 - Women and children (and some men) in regard to domestic violence and abuse.
 - Older people – through their use of alcohol or fear of others.

Q38. 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 contributes to maintaining the problems facing such groups? Which off these factors should interventions be aimed at?

A. Many key factors relate to social exclusion – these can be related, in turn, to:

- Mental Health
- Education and employability
- Personal income
- Accommodation situation
- Drug misuse

Q39. 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?

A. Joint needs assessment and strategic planning should form the basics for joined-up responses. This should be across the whole spectrum of need and relevant agency responses.

In Dudley a hostel for people with accommodation problems has become a focal point for additional and joined up services on-site as with supporting-people workers and specialist counselling for substance misuse.

Q40. 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?

A. Good partnership working can provide for an appropriate range of balanced service provision. However, the lack of adequate resources often prevents optimum provision.

"Best Value" solutions should be the result of a researched approach, backed by appropriate resources that are a planned part of "core" provision.

The marginal position of alcohol harm reduction and associated activities will only result in marginal achievements.

Q41. 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?

A. No comment.

Q42. Given clear objectives what is the evidence on the effectiveness of these approaches? What do they actually achieve? How can their effectiveness be measured?

A. No comment.

Q43. How well is the sensible drinking message reaching its audience? Is it sufficiently clear? What is the evidence on penetration and behaviour?

A. No comment.

Q44. 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?

A. No comment.

Q45. Should particular groups be targeted for information and communications? Is there a need to provide more intensive alcohol education to groups other than young people (e.g. elderly drinkers)?

A. No comment.

Q46. 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?

A. No comment.

Q47. What role is there for families/parents as role models 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?

A. No comment.

Q48. 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?

A. No comment.

Q49. What can be learnt from educational initiatives in the field of illegal drugs?

A. No comment.

Q50. Do you have views on the existing regulation of advertising on alcohol?

A. No comment.

Q51. Do you have thoughts on the likely evolution of the alcohol industry over the next decade?

A. The alcohol industry needs to be engaged with the government's Crime and Disorder agenda and play a full and committed part, on the basis that 'the polluter' pays.

Q52. 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 a useful evidence on which we might draw?

A. No comment.

Q53. How far do you see research and development creating innovative market led solutions to the problems of alcohol misuse?

A. No comment.

Q54. 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?

A. No comment.

Q55. Are there other commercial interests, which can influence drinking behaviour?

A. No comment.

Q56. 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?

A. Reference is made to the Centre for Health Economics at York University – N.B. Christine Godfrey

Q57. 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 particular helpful methods for assessing costs and benefits of which we should be aware?

A. Reference is made to the Centre for Health Economics at York University – N.B. Christine Godfrey

Q58. 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?

A. Reference is made to the Centre for Health Economics at York University – N.B. Christine Godfrey

Q59. What are the economic benefits of having an alcohol industry? Can we easily quantify them?

A. Reference is made to the Centre for Health Economics at York University – N.B. Christine Godfrey

Q60. 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?

A. Suggest that known research and operational practice is resourced through Alcohol Concern.

Q61. Are there particularly effective workplace based initiatives designed to tackle alcohol misuse that we should be aware of?

A. Suggest that known research and operational practice is resourced through Alcohol Concern.