

NATIONAL ALCOHOL HARM REDUCTION STRATEGY – CONSULTATION DOCUMENT.

RESPONSE TO QUESTIONS 1 TO 40 ONLY BY ACAD – ADVICE AND COUNSELLING ON ALCOHOL AND OTHER DRUGS (REG. CHARITY)

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

Response: 1) The Government is already involved through existing legislation; the impacts of health, crime and social care; the tax the industry generates and the jobs it creates. It is the Government's role to step and to try to reduce the misuse of alcohol and this has occurred at many stages in our history. We are at one of the stages now with over 33,000 people a year dying from alcohol and increasing problematic use amongst key groups, such as young women. It is the Government's duty to reduce the alcohol related harm and risks to its citizens, in the same way as it has set out to reduce the harm of illicit drug misuse. After all alcohol is a legal drug.

2. How far is alcohol misuse a matter of individual responsibility and when does the Government have a responsibility to intervene, whether through services, legislation or persuasion?

Response: 2) Alcohol misuse is the responsibility of the individual, the partner, the family, the friends, the workplace, the alcohol industry, the alcohol distribution trades, the community, central government and local government. All have important roles and all are affected, albeit in differing ways, by problem drinking. We all have a responsibility.

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

Response: 3) Clearly, a legal drug is a more complex matter than an illegal drug, in terms of rights of the individual. The right is already in place to legally use alcohol for adults. However, greater liberty for the majority should not be at the expense of vulnerable minorities. Fear of crime and repeat victimisation is a serious problem for those living in areas where regular alcohol related disorder occurs.

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

Response: 4) There are many differing roles and responsibilities depending on who you are? We expect all concerned to behave responsibly but obviously this is not always the case. The use, promotion and sale

of alcohol should not be left to market forces to determine as we are dealing with a drug that can cause severe harm.

5. What principles should underpin a national harm reduction strategy?

Response: 5) The early prevention of alcohol related harm; the identification of harm; the provision of specialist, community based, help services with secure funding across the country; and the reduction in current levels of harm, identified by key indicators such as per capita consumption for vulnerable groups. The relationship to illicit drug misuse and nicotine use should also be considered important and influential. People with alcohol problems should be considered in control of their actions, like non-problematic drinkers, rather than suffering from a disease.

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

Response: 6) Any level of alcohol related harm that damages the consumer's life, either physically, psychologically, socially or legally. Important others, such as a partner or child, who are harmed by the continued drinking of someone close to them, should also be considered in need of help.

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

Response: 7) An alcohol strategy that intends to impact on the current level of problems must seek to influence macro and micro factors. Consequently, targets must include price, access, frequency (daily or binge use) and per capita consumption for vulnerable groups, such as women and young people. Individual, familial and community change should also be influenced in ways that can be measured. Prevention should be targeted rather than through 'broad brush' approaches.

8. 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 on influencing behaviour?

Response: 8) Society is changing constantly and with these changes come particular challenges. Any strategy should be able to recognise and adapt to changes as they start to develop. These social changes will influence drinking cultures for some groups, for instance alcopops have introduced women to alcohol earlier and have been an influence in the increasing levels of consumption and onset of drinking for women.

9. One group that we initially need to focus on specifically is young people, where the evidence suggests a rise in consumption, particularly for 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?

Response: 9) We need to recognise that some groups do not get ready access to helping services that meet their own cultural and language needs. Consequently, they do not get equality of access to services and as such should be given a special emphasis. Asylum seekers are also disadvantaged in similar ways. The needs of women and young people have already been mentioned. We also feel that children from families where there are problem drinking parents are in need of supportive services to help them deal with the current problems but also to help prevent them becoming problem drinkers themselves as a consequence of their familial experiences. ACAD provides an IRIS Service to partners of problem drinkers in Bristol and we feel services such as these are few and far between nationally and need developing.

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?

Response: 10) The strategy should aim to reduce alcohol related harm. Economic arguments and the needs of the alcohol industries will take care of themselves. They have the finance to manage their own situations. The strategy must not be sidetracked by the needs of the more powerful within the industry. For example, the industry has delayed the introduction of a lower drink limit despite the continued number of deaths and harm on our roads resultant from drink driving. The strategy needs to take a strong stance and do what is good for the public health.

11. Is there such a thing as a recognisable drinking culture and if so what does it look like? What are the factors that influence it – for example are there any sharp regional differences? Does it look different for different age groups?

Response: 11) There are many drinking cultures and an individual or group may be subject to a number at any one time, such as family and workplace drinking. There are regional differences as well as class differences. This is why the Strategy needs to be targeted in many of the areas it wishes to influence.

12. What factors influence behaviour – fashion, marketing, family background, education and information, financial, legal and regulatory, scientific, environmental? What are the most influential in your view? How easy is it to exert influence through these factors?

Response: 12) There are many factors that impact on an individual, family or group and these may differ over time and a number at any particular time. The most influential are economic, marketing, regulatory, legal, environmental and family background.

13. How do attitudes to risk affect alcohol use?

Response: 13) Given that alcohol disinhibits with increasing dosages, it is difficult not to state that there is a relationship between attitude

to risk and alcohol. Hence, the increased risk of offending behaviour for many offenders when drinking heavily.

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

Response 14) Any level of alcohol related harm that damages the consumer's life, either physically, psychologically, socially or legally. Important others, such as a partner or child, who are harmed by the continued drinking of someone close to them should also be considered in need of help. It is important to recognise that some people do not have to drink heavily to experience harm, for example an elderly person; a person with a temper problem or a severe mental health problem. Heavy drinking is a risk factor in respect of harmful drinking but not every problem drinker necessarily drinks heavily.

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? What are the gaps in the evidence?

Response: 15) There is considerable evidence nationally and internationally. The Centre of Health Economics at the University of York is an excellent starting point.

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

Response: 16) Again this is well documented already. Please refer to Alcohol and Public Health - Griffith Edwards (Ed). ACAD sees approximately 2,500 people a year for alcohol and other drugs problems, many of which are referred by their GP. We see the connection on a daily basis.

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?

Response: 17) The main keys to the prevention of alcohol dependence and serious alcohol misuse are the macro influences of targeting, supply and price. These are areas that the government can directly affect through taxation, licensing legislation and regulatory mechanisms. The dramatic increases in alcohol consumption by women and young people and the related harm have been a direct consequence of price, increased access and advertising targeting. New drinks have come into the market place that have been targeted at young people and women and it is no surprise that consumption in these groups has risen to the degree it has. The Government must take control of the market place. For example, the Portman Group's voluntary code of practice for the industry's alcohol advertising is woefully ineffectual and the responsibility should be given to local government licensing and trading standards departments - this can be attached to the coming transfer of licensing responsibilities from magistrates to local authorities. The ready access to alcohol under liberalisation of the licensing laws may be good news for many people but does little to reduce the problems of consumption for risky drinkers, heavy drinkers and those with dependencies. There

are currently too many pubs operating family rooms that are, in effect, conditioning children and young people to accept excessive drinking and smoking as a norm. The health of children must surely be at risk through passive smoking and the risk of alcohol related disorder. Health promotion on alcohol issues in schools should be a part of the core curriculum and presented by appropriately trained teachers from within the school establishment. There is no evidence, other than anecdotal, that supports the efficacy of external gimmicks, such as the DARE Programme and Life Skills Education Centres as a part of schools health promotion. Targeted public campaigns that promote the understanding of alcohol units and personal consumption levels should be recommended and the alcohol industry should be required to label drinks with the amount of alcohol units they contain. Also there should be a harm tax levied on alcohol products to help pay for the social, familial and personal harms caused by alcohol - this income should be used to financially support hospital and community based initiatives that try to tackle such problems. Alcohol training for social and health care staff should be contained within core professional training (such as the Diploma in Social Work) and should be more than just half a days lecture - which seems to be the current norm at best. Alcohol placements should be encouraged within alcohol helping services and students must be assessed on their ability to identify alcohol problems and work with/refer on appropriately.

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 nurse or doctor 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?

Response: 18) Brief interventions have an important role to play in identifying and working with people at risk and those with early stage alcohol problems. Community based services, in the statutory and non-statutory sectors, could be much more fully involved in such approaches. For example within South Gloucestershire, ACAD - Advice and Counselling on Alcohol and Drugs - is a local specialist, charity that offers public, helping services that use of brief interventions. There is also a need for the greater promotion of screening tools, such as the 'CAGE' and the 'SADQ' tools, within health and social care settings.

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?

Response: 19) The current emphasis on NHS Services to people suffering from severe alcohol dependency does not adequately reflect the range of alcohol related problems within communities and the current arrangements are very patchy and ineffectual given the size of problems within the communities they are intended to serve. There is gross under funding and there has been a policy shift away from alcohol related harm towards the other drug problems as per the National Drug Strategy. ACAD is struggling to provide services due to policy and funding neglect, for example we had our funding reduced to £30,000 p.a. by South Gloucestershire Drug Action Team for 2002/2003 despite been the primary deliverers of alcohol services to 225,000 residents - we see 220 per year! Emphasis needs to be on meeting the current local alcohol

problems, early detection and prevention. This should include services to assist the families, partners and friends of problem drinkers who are often suffering as a consequence - an example of such a service is the IRIS Project ran by ACAD.

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

Response: 20) Drug initiatives have shown us that community based, rapid access services are very important and that attached to specific issues, such as offending, people can be encouraged to change their behaviour. We have seen similar effective interventions for alcohol problems, for example drink driver schemes and the 'PACE' Alcohol Offender programme, which is ran by ACAD for the Probation Service. Schemes like these need to be developed further. Gateways to services should not be restricted to the Courts alone though, as there is a greater need for gateways to be developed within child protection services, looked after children, mental health services, schools, further and higher education, the workplace and youth services. Whilst drug initiatives have developed some interesting practices, there are also lessons to be learned from their mistakes.

For example, we should seek to avoid policy bureaucratisation, over centralised direction and the over emphasis on criminal justice issues at the expenses of other similarly important areas.

Fortunately, the alcohol field will not be burdened with the need for drug substitution services, such as methadone. However we must avoid an emphasis on the use of antabuse and other alcohol reactants to control behaviour. Like the National Drugs Strategy, we must seek local partnership agreements and active participation.

21. How in your experience can we minimise and prevent injuries that are presented at A & E Departments as a result of alcohol related assaults (often with glasses and bottles) or home and workplace alcohol related accidents ?

Response: 21) With regards to glass and bottle injuries, a significant number of these injuries can be prevented at the point of alcohol sale through the use of glass/plastic containers that disintegrate when smashed. The disintegration removes the glass or bottle as a weapon. This change should be imposed on the alcohol distribution industry as they have displayed a clear reluctance to resolve this serious problem. There is a need for urgent action in this area. Other assaults, which are the result of alcohol related disorder in town and city centres, can be reduced through coordinated crime prevention activities, such as the control/licensing of door security staff, limits on the number of alcohol licenses in problem areas, control of the citing of bus stops and taxi ranks at weekends. Workplace activities to reduce alcohol related accidents should emphasise that the workplace is not a suitable setting for consuming alcohol, both in terms of health care but also productivity and resulting profit. The home setting is more complicated and ties into social, childcare and other familial responsibilities. The relationship between alcohol and child protection, sexual abuse and domestic violence is well documented. With almost a million children living with one or more problem drinking parent, the family is an important area of focus and will require a range of interventions and preventative initiatives.

22. 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?

Response: 22) The relationships between alcohol use and mental health problems are complex but significant in a number of areas, such as depression, anxiety neuroses, suicidal behaviour, confusion in older age and the exacerbation of psychotic disorders. This has been underrecognised to date primarily due to poor professional training and a misunderstanding of the role of alcohol in mental health problems. Each specialist Mental Health Team should have a trained alcohol worker as apart of his or her multi-disciplinary team.

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?

Response: 23) The relationships between alcohol use and crime, including anti-social behaviour and disorder, were well documented before the same connections were made in respect of illicit drugs. The work in the late 80's and early 90's in many city centres, for example Coventry and Newport, have shown what benefits can occur from co-ordinated local, environmental and social action by local authorities, police and the licensing trade. Some interesting work in rural areas was done during this period as well. What has been lost is the will to follow this through politically in the 90's. This is despite the excellent research carried out by the Home Office Research Unit, particularly Mary Tuck. We need action not further research - community safety partnerships and YOTs would be the best vehicles for responding.

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?

Response: 24) There has also been a long-term recognition of the relationship between alcohol use and offending behaviour, particularly with regards to young people. This is in respect of oneoff, often opportunistic offences, and repeat offending. ACAD runs a Probation 'PACE' programme across Bristol, B&NES and North Somerset for alcohol related offenders and we influenced lower offending rates for those taking part in the scheme.

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 reality? What fuels the perceptions and are they accurate ?

Response: 25) Please refer to the Home Office Research Unit's work in the early 90's for the evidence. The moral panic around illicit drug use has taken the emphasis away from alcohol and disorder but the problems still persist relentlessly.

26, 27, 28 and 29

Please see Response: 23)

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

Response: 30) No they should be intelligence led and focused on repeat offenders. Crime should also be environmentally designed out, such as Safer Car Parks Schemes.

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?

Response: 31) This is very difficult to achieve in practice. The emphasis should be on locally agreed policies for the citing of drinking and off-licenses to avoid saturated areas and also be for staggered closing times to prevent all drinkers leaving establishments at the same time.

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?

Response: 32) Street Drinking Bye-Laws are ineffectual by themselves and need to be a part of a locally agreed package of partnership measures designed to tackle local drinking and disorder problems. In many areas the Street Drinking Bye-Laws would not work due to the lack of a definable area and the nature of local problems. For examples, the Bye Law worked well in Coventry, Leamington Spa and Chester but failed badly in Scarborough and Redditch.

33.

Please see Responses: 3) and 4)

34. Drink Drive policies are generally acknowledged to be successful. What can we learn from them?

Responses: 34). Over the last 20 years we have seen significant changes in behaviour relating to drink driving however the problem has not gone away and needs to be further reduced. For example, police random stop campaigns should be year round and not just at Christmas. Also the drink drive level needs reducing to 50mg in line with the rest of Europe. What we can learn from this experience is that commercial alcohol interests can prevent public health action taking place. During the last review, the Health Secretary determined the needs of rural pubs (he felt the move would take trade away from them) were more important than the health needs of the public. This was an unacceptable position.

35. Domestic violence is often associated with alcohol misuse.

Responses: 35). There is a significant relationship between alcohol and violence, particularly within partner relationships. The trauma involved is great and has an appalling impact on the victims and their children. This should be an important focus for services. I am not aware of any specialist response involving action on alcohol.

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

Responses: 36). Children and young people living with one or more problem drinking parents are at significant risk of developing later

alcohol problems themselves as well as mental health problems. They may also be struggling at school and have difficulty making friends. This is a high risk group with little if any support. The strategy must address their needs, given that there may be one million of them at any one time. Binge drinkers are at risk due to the severe health and social risks that can be linked to that style of drinking. Another group of concern is children looked after by the local authority social services and children and young people who are mixing alcohol and other drugs, such as methadone.

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

Responses: 37). People in older age, particularly 70 years plus, for whom moderate drinking has become problematic due to the consequences of physical ageing and the impacts of retirement and bereavement. People with mental health problems who may be experiencing such problems as a direct consequence of their alcohol use or may have difficulty managing an existing mental health problem because of the difficulties added on by alcohol misuse, such as drug interaction. Also people with learning difficulties may find alcohol generates problems for them in managing their independent living. Homeless street drinkers have particular needs that the Strategy should seek to help reduce, especially those with residual, alcohol related organic brain damage. Pregnant women should also be targeted to try to reduce the level of alcohol foetal syndrome births.

38, 39. and 40 Complex needs – homelessness and mental health ?

Responses: 38). Services can achieve only a limited amount of impact if basic needs, such as housing, food, clothing, and shelter, are not met. Supportive housing is a key issue for helping homeless drinkers with complex needs to sort the problematic drinking and/or drug use out. The Strategy will need to take account of these needs.

39). Few of the existing specialist hospital and community alcohol services meet the needs of homeless people. There is a shortage of wet and dry accommodation.

40). Our experience at ACAD is that there is an acute shortage of staged housing for homeless people who are trying to deal with their drinking problems. There is also a shortage of wet accommodation for those with significant, alcohol related, brain damage who need to be looked after.