

British Association for the Person Centred Approach



14th January 2003

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

Dear Madam/Sir,

Please find enclosed a response to the National Alcohol Harm Reduction Strategy consultation document.

If you would like any further information or clarification please do not hesitate to contact me.

Yours faithfully

Sheila Haugh
Convenor

Tel: 0790 996 5136
Email: Shaugh@bacpa.org.uk

BAPCA
BM-BAPCA
LONDON WC1N 3XX
Telephone: 01989 770 948
Email: enquiries@bacpa.org.uk
BAPCA is a registered Charity number 1044077
Web site: www.bapca.org.uk



Response to the National Alcohol Harm Reduction Strategy Consultation Document.

Introduction.

The British Association for the Person Centred Approach exists to bring together all those interested in the person-centred approach. The person-centred approach developed from the work of the psychologist Dr. Carl Rogers (1902 – 1987). He advanced an approach to psychotherapy and counselling that, at the time (1940s – 1960s), was considered extremely radical if not revolutionary. Originally described as non-directive, this therapy moved away from the idea that the therapist was the expert and towards a theory that trusted the innate tendency (known as the actualising tendency) of human beings to find fulfilment of their personal potentials. An important part of this theory is that in a particular psychological environment, the fulfilment of personal potentials includes sociability, the need to be with other human beings and a desire to know and be known by other people. It also includes being open to experience, being trusting and trustworthy, being curious about the world, being creative and compassionate.

The British Association for the Person-Centred Approach (BAPCA) is a membership organisation representing those people using the person-centred approach in their work. This includes teachers, social workers, health care workers and those in the helping professions generally. The majority of BAPCA members are counsellors/psychotherapists who work using client-centred counselling/psychotherapy. They work in both statutory and voluntary agencies and many of them are directly involved in work with people and their families experiencing problems with alcohol use.

The numbers refer to the consultation document numbering.

The Principles That Should Underpin the Strategy

1. As the consultation document points out, in Britain 92% of men and 86% of women drink alcohol and it seems fair to say that alcohol plays a significant part in many peoples' lives both personally and culturally. For numerous people, their drinking is an enjoyable part of their lives. However, it is clear that drinking also results in much misery for both those whose drinking is out of control and for those people around them. Alcohol is a mood altering drug that is socially acceptable in much of Britain's culture. The production, sale and consumption of alcohol cuts across all areas of national life and the Government is in a unique position to be able to take a unified approach to this issue. Additionally, any action regarding problematic drinking needs to take into consideration a wide range of responses and actions. Only the Government is in a position to implement such responses and actions throughout all Government departments. Government intervention becomes justified when alcohol use becomes detrimental to the physical and psychological health of a significant number of people.
2. In the final analysis, any use of alcohol is a personal choice and therefore an issue of personal responsibility. However, personal choice is influenced by many factors and the government has a responsibility to provide information and education in order that the individual's choice can be as informed as possible. It is also the case that due to the psychological effect of alcohol (including the lowering of risk assessment abilities) and the addictive nature of alcohol itself, the Government also has a responsibility to intervene when the use of alcohol has become detrimental to physical and psychological health.
3. The community has a right to feel safe from the effects of alcohol. At the same time the individual has the right to make a choice to drink. The balance can be found in how far the *behaviour* of each drinker impinges on the rights of the community ('community' is used in its widest sense meaning partners, children, the local and wider community of the workplace etc.)
4. (i) Consumers need to use alcohol responsibly. There is evidence that this is indeed happening. For example, it is now clearly less acceptable to drink and drive than it was ten years ago. However, there needs to be more information about the effects (harmful and otherwise) of alcohol consumption in order for people to have the knowledge in order to be able to act more responsibly.
- (ii) Voluntary groups already take a great deal of responsibility in this area and in fact seem to provide the major role in offering services for those with problem drinking (and their families). They need support in their work, for example with more secure and substantial funding. Staff need to be trained in order to offer services that are both appropriate and effective.

- (iii) Commercial interests are particularly important and have a responsibility provide information on their products. However, it is perhaps too much to expect that commercial interests will be put second to health concerns. For example, the creation of ‘Alco pops’ for the youth market shows little regard for the detrimental effects of long term alcohol use and drinking patterns generally.
 - (iv) Others; all parts of society are effected by alcohol use and it is encumbrant on society to be aware of their responsibilities. Again, people need education and information in order to be able to act in ways that are responsible to others. They also need to know that they will be supported in their actions. For example, in the workplace, workers need to know that a colleague will get support and help rather than face disciplinary action if they are reported for alcohol mis-use.
5. The principles that should underpin a national alcohol harm reduction strategy are
- Freedom of choice for the individual
 - That behaviour should not be detrimental to another person
 - Services are integrated and based on effectiveness.
 - Services are easily accessible

These principles apply to the individual who is drinking and for the people around the drinker. Inevitably there will be tensions in these two freedoms. However, by concentrating on the *behaviour* of each person, and whether the behaviour is detrimental to others, the difficulties in these tensions will be lessened.

In this context effectiveness does not simply mean a reduction in consumption of alcohol. Rather, it would mean how far the issues that invariably underlie problem drinking are being resolved.

The Cultural and Behavioural Issues Around Alcohol Use and Misuse

6. In line with the above our definition of alcohol misuse is;

Any short or long term use of alcohol that is experienced by the individual as detrimental to their physical and/or psychological health. Additionally, any short or long term use of alcohol that is experienced as detrimental to the physical or psychological health of those around the drinker

The overriding factor taken into account in this definition is that each individual is unique and that the effects of alcohol, both psychologically and physically, cannot be stated as a universal. It is vital that the psychological reasons for problem drinking are recognised as being as important as the health outcomes of alcohol use. There is no clear evidence to support any one view of the aetiology of problem drinking. Whilst there maybe influences in alcohol mis-use, such as a genetic component, the addictive personality, the family background or social pressures, the case is not proved for any one of

these being a conclusive factor. Until such a time as a particular theory can be proved it is dangerous and irresponsible to define alcohol mis-use in any other way than the experienced effect to the drinker and to those around them. We cannot emphasise this point too strongly. It is clear that high levels of alcohol consumption are sometimes used by people to help them through traumatic times, for example bereavement. We would not necessarily describe this as alcohol mis-use.

7. There appear to be three clearly discernable drinking patterns. Firstly, non-harmful, pleasurable social drinking that an alcohol reduction strategy does not need to address (occasional alcohol use). Secondly, there is the pattern of binge drinking and lastly a pattern of drinking whereby consumption of alcohol is continuous – often resulting in harm (habitual). It is these last two patterns that an alcohol reduction strategy should seek to affect.

Harmful drinking patterns are encouraged by the habit of drinking against a dead-line due to licensing laws. The potential for harm is maximised by people drinking as much as they can before 11.00pm and then all being in the same place, leaving pubs in a similar state. The role of government here is clearly to change the licensing laws that create such pressurised drinking patterns.

Habitual drinking patterns often develop over time and can be a result of lack of knowledge concerning the dangers of habitual alcohol use. The government's role here is to initiate and maintain education programmes concerning alcohol use.

All these patterns are susceptible to change as are any patterns of human behaviour. If we accept that human beings are doing the best they can in the circumstances they find themselves, and with the options they have available, we can influence the resulting behaviour by changing the circumstances and widening the options.

Problem drinking is often a response to feelings of powerlessness and deprivation. The Government needs to take more serious measures to address the economic and social inequalities that leave many people feeling they have little power to influence the direction of their lives.

Widening options could include education and information about the limitations and dangers of alcohol, particularly to young people, and the promotion of ways of belonging, relaxing, having fun, feeling desirable, feeling excited etc. that do not include alcohol.

8. It is clear that there is a relationship between trends in drinking and wider social changes. There has been an increase in drinking by women as a result of more equality with, and economic independence from, men. This changing relationship between men and women means it is less acceptable now in many sections of society for men to spend all evening in the pub, but this has led to more drinking in the home. Likewise, women are more likely to spend an evening in the pub. There has also been an escalation in wine drinking in the home, due to changing social trends, for example the influence of the EU and cheap travel abroad. That more people are living in single person households seems to have created a situation where it is now acceptable to drink alone at home, whereas this used to be seen as a sign of alcoholism. Later marriage means that more people have a larger disposable income, so can indulge in heavier drinking without the responsibilities of home-owning and child care.

It seems children and young people are encouraged to be more adult at a younger age, perhaps as a result of the plethora of information available via the media, and perhaps as a deliberate strategy to alert them to the dangers of the world. Ernesto Spinelli (October 2002) draws our attention to the blurring of the boundaries between childhood and adulthood, which may be a contributory factor to the increase in problem drinking amongst young people. We need to focus our attention on influencing behaviour particularly in young people, probably most effectively through media representations of the role of alcohol.

9. People working with Asian communities have described an issue of problem drinking that is kept very secret. These communities are unlikely to use mainstream, predominantly white, alcohol services. Problem drinking in these communities is probably best addressed through agencies and personal already working within those communities.
10. We have already referred to the enjoyable aspect of social, non-problematic, aspects of drinking. There are many rituals associated with alcohol – the toast for special occasions for example. The balance needs to be found, on the one hand, between education on the dangers of alcohol use and, on the other hand, of not demonising alcohol use.
11. Given this consultation concerns a national strategy we are not clear if the question refers to England or Britain. However, one of the outstanding features of British/English drinking culture, compared to drinking on the continent, is the viewing of drinking as an activity in its own right rather than an accompaniment to other pursuits. As a consequence, we have many establishments dedicated to the consumption of alcohol. British licensing laws create a culture of impending scarcity, the fact that there is time when it will not be possible to get a drink. We believe this affects people psychologically in to feeling an urgency about drinking. This is a factor that is not apparent on the continent. We suspect that class differences are more significant than regional differences, particularly in the choice of drink and the place of drinking. We suggest that though drinking patterns are different for different age groups in terms of where drinking takes place and what is drunk, problem drinking is similar across age and class, certainly in its end results.
12. It is clear that family background plays an important part in the development of problem drinking. However, not all people who been affected by problem drinking in their family go on to develop their own difficulties with alcohol (in fact some people respond by becoming teetotal). Clearly, alcohol is also associated with glamour, success, good times and excitement and is seen as an attractive option for entertainment and perhaps even sophistication. In our opinion, the image of drinking has as great, if not greater impact on alcohol use as family background, although this is not necessarily on a conscious level. Alcohol is very rarely represented as dangerous, nor is it shown as being in the same category as other mind altering drugs. Very few people are aware of the physical addiction of alcohol, nor the dangers of non-medically supervised withdrawal from heavy alcohol use.

Financial, legal and regulatory factors are also very powerful influences. Studies in Europe have shown that problem drinking is reduced when the price of alcohol is higher and we believe that a parallel can be drawn with the reduction of smoking. Although there are still problems with young people and smoking (particularly young women) it is no longer seen as attractive as it once was. It is no longer seen the pinnacle of sophistication and these days it is rare, for example, to see people smoking on television. We believe that lessons can be learnt from this. The government has a right and a duty to influence the representation of alcohol, where, when and how alcohol is advertised.

Alcohol use also has to been seen in the context of how others drugs (particularly illegal drugs) are portrayed. There are many agencies that argue the use of alcohol is far more destructive than, for example, the use of cannabis. This view is not represented in government policies.

13. As a general statement, people are more willing to take risks when they feel they do not have too much to lose. Therefore, problematic drinking is going to proliferate where there is deprivation and poor quality of life. To add to this problem, alcohol, as a drug, psychologically reduces the ability of risk assessment.

Health: Prevention, Treatment and the Impact on the NHS

14. Harmful drinking can be defined as any level or pattern of drinking that an individual experience as detrimental to their social, personal and working life. This includes both the drinker and those in the drinkers circle. Additionally, harmful drinking can also be defined as drinking that has become damaging, or has the potential to become damaging, to physical and psychological health. The factors that we would take into account concerning whether a person's drinking is heavy and/or harmful would be such things as their self assessment of the effects on personal and social relationships, ability to carry out working duties (be this paid, unpaid or in the home) and the effects on their physical and psychological well being.
15. We assume that through this consultation process the strategy unit will collate evidence for health costs and health benefits, key pieces of evidence and identify gaps in the evidence from organisations better placed than BAPCA in the field. However, it is clear to us that health costs include treatment of the direct physical consequences of the drug (liver damage etc), indirect physical consequences (accidents etc) and psychological costs. We believe that it is noteworthy that the health benefits of alcohol are, at least to the general public, confusing and contradictory.
16. As the consultation document points out, it is clear that there are many costs to the NHS due to alcohol use, both in service provision and in the wellbeing of healthcare workers themselves. It is noteworthy that these costs do not arise only from the individual drinker themselves. Those affected by the individual who drinks include parents, spouses, family, friends and indeed the wider

community. Alcohol is a significant factor in many incidences of domestic violence which is a cost to the NHS both to the emergency services and to GPs. In particular, depression and mental health problems can be experienced by those in close relation to the drinker, thus the indirect costs to the NHS are even higher. However, additional to these costs to the NHS, there are costs to other government departments. Family breakdown through alcohol use can lead to input from the Department of Health (social services); homelessness associated with alcohol use (and family breakdown due to alcohol use) brings in housing departments. We believe the role of alcohol can be hidden in many of these situations and it is possible that its influence is actually underestimated. However, we are not aware of research in this area.

17. First and foremost, the most appropriate prevention methods are those of giving people fitting information and knowledge regarding the effects of alcohol. This information needs to be non-sensational and, most importantly, sustained. There is little point in scare mongering – it is clear that the effects of such campaigns are extremely short lived, as was seen in the early eighties with the AIDS safer sex campaigns. Additionally, the information needs to be continually available in much the same way the anti-smoking campaigns have been undertaken.

The forms of training most appropriate for professionals will cover three areas;

- (i) training that gives them clear understanding and knowledge of the physical and psychological effects of alcohol
- (ii) training that helps them to assess the appropriateness (timing) of offering such information to a person at any given time
- (iii) training that helps them to work with those who are drinking and those who are affected by someone's drinking, in a understanding and non-judgemental manner

18. We are not clear that those at risk are effectively identified, this being for a number of reasons. Inherent in this issue is that the problem drinker, or the person affected by a problem drinker, does not have this tattooed on their forehead and they may only present to GP surgeries or hospital with the effects of alcohol use. Additionally, and certainly in urban areas, doctors and A&C departments very rarely have the time to explore the underlying cause of the presenting problem/injury.

Further to this, if a problem is identified there can be difficulty in accessing services. Statutory services are known for long waiting lists and very specific referral criteria. Furthermore, not all GP practices have counselling services or knowledge of existing voluntary services in their area. Clearly brief interventions maybe particularly useful for those people who have identified their problem and simply need support in making changes.

The consultation document refers to the 'doctor or nurse' discussing 'a patient's drinking'. We would like to make that point that there are many voluntary agencies that offer brief, time limited counselling (counselling as defined by the British Association for Counselling and Psychotherapy) that is not focussed on levels of drinking. We believe that it is only after establishing a relationship of trust, where the individual feels free from threat or

judgement, can a person acknowledge to themselves that their drinking is causing them (and/or those around them) problems. Behavioural change is then more likely to happen and, more importantly, to be sustained.

Some of our members have reported that they are being required to organise their counselling work within a 'drinking reduction' regime. We believe that whilst this may help some people it does not help all people. In our opinion this follows a medical model of alcohol treatment and does not allow for individually focussed interventions.

In the experience of some of our members brief interventions, counselling and otherwise, do work. However, as far as we know, there have not been the resources available to research the long term outcomes of brief *counselling* interventions.

19. Current treatment for alcohol dependency and hazardous drinking clearly work. However, there is an important caveat to this statement. They are not sufficiently tailored to meet differing individual needs and therefore, de facto, only work for the individual they work for. Although alcohol includes a physical dependency (unlike many other drugs where the dependency is primarily psychological), it is clear that a great deal of problem drinking is a response to life situations which people find intolerable. Services which focus solely on drinking levels and habits, do not respond to the underlying issues that have prompted the problem drinking in the first place. In consequence, there is a group of people who will not find the majority of government services currently available appropriate to their needs. Guidance does need to be given to commissioners of local treatment services in order to help them provide and support a wider range of interventions.

Access for individuals to services should be as varied as possible and at the point of need. Importantly, access needs to be available for people who identify that they are getting into difficulties with alcohol use. A truly effective national alcohol strategy will include this preventative aspect of the problem. Access to these services would include through GP's as is possible now; through social services and include self referral to de-toxification units. In tandem with this is an educational aspect – that people know the services are available. We feel very strongly that self-referral should be made more easy and that this would go some way to managing the unique needs of the individual drinker.

20. Drug prevention and treatment has a long history and has a great deal to teach us. Information that is clear, measured and offered in a way that is appropriate (i.e. non-sensationally and at the level and interest of the receiver) is one of the most important aspects of drug misuse prevention. Services that are tailored to meet individual needs are also important. One group of problem drinkers are quite chaotic, very like one group of drug mis-users. Services that demand appearance at a given place at a give time do not meet the need of the chaotic drug user; this is also true for the chaotic alcohol user.

Most clearly, long term, problematic drug taking is associated with problematic external situations (homelessness for example) and/or psychological difficulties. We believe this to be true of the majority of problem drinking. Drug users who decide to try and change/end their drug use need to be responded to whilst, psychologically, their will for health is

uppermost. This is also true for the problem drinker. A referral taking six months is much less likely to harness the persons' internal resources for giving up or moderating their alcohol intake. As effective psychological interventions rely to a large extent on the internal resources of the client (Bozarth, 1998), services that are able to respond quickly to a request for help are very important.

Lastly, the development of services for drug users included a broader access base, for example, support for voluntary agencies, government drug services such as needle exchanges, situated in non-government projects, agencies providing advice, information and counselling. These initiatives brought many more drug users/mis-users into contact with services. In some instances drug services were/are integrated with other services, thus allowing for issues of drug use to be addressed before they were creating problems in a person's life and as part of a holistic approach to physical, psychological and social health. We suggest that these approaches to drug treatment and prevention could be very usefully applied to the problem or potential and actual alcohol use.

21. We are not sure what measures the government could take to minimise and prevent injuries – or indeed if that is the government's role over and above being the lead body in disseminating information about the effects of alcohol and services available. Worthy of mention in our opinion, and something a National Alcohol Harm Reduction Strategy could initiate and support, would be greater discussion with pub landlords and the like as to how to carry out their responsibility not to serve patrons who are very clearly intoxicated. Currently, some prospective licensees receive this information but are not given any training in how to carry this out in a way that does not provoke confrontation.

The government's role in the home is even less clear and again we would see the government as being the lead body in clear and exact information regarding alcohol.

In the workplace, information should be given to workers in the context of health and safety policies and procedures. Additionally, workplaces should be encouraged to be sympathetic to potential problem drinkers, perhaps encouraged to offer counselling services to workers who feel they may be a risk. Such initiatives as these would encourage workers to address their alcohol concerns before they became problematic, thus reducing alcohol-related workplace accidents.

22. We argue that, in the vast majority of cases, alcohol mis-use follows from mental health issues. We acknowledge the different theories concerning the aetiology of alcohol mis-use, for example the 'addictive personality.' However we feel that the current body of knowledge is not advanced enough to state with certainty the causes of alcohol mis-use. It should be noted that when we use the term 'mental health problems' we are not necessarily or solely referring to those conditions described in DSM IV or ICD 10. We define mental health problems as meaning feelings or behaviours that are detrimental to the physical, psychological and/or social functioning of an individual. Notwithstanding this comment, as a drug, alcohol has a depressive aspect to physiological effects. Thus depression can be exacerbated by the use

of alcohol and alcohol can precipitate depression. Furthermore, alcohol is clearly implicated in cases of suicide. However, it is not always clear if alcohol helped someone to do what they wanted to do (attempt suicide) or if it affected their risk assessment. Either way it is clear that alcohol use can play a decisive role in suicides.

From the above it should be clear that in practice, we believe it is difficult to distinguish between mental health problems being a result of alcohol misuse, or alcohol misuse resulting in mental health problems and it would be dangerous to make such a definitive statement. The individual drinker needs to be responded to from their frame of reference.

Therefore services are best co-ordinated in such way as to maximise the possibility of a service user receiving the support and intervention they feel is most appropriate. So far we have argued that the major role for a government strategy in this field lies in the dissemination of information. In this context, it includes helping agencies, both statutory and non-statutory, to be aware of each others work and to not duplicate work that is already in existence. It also includes the provision of new services in areas where choice of treatment is limited.

Crime, Disorder and Anti-Social Behaviour: the Effects on our Surroundings and Community

23. We are not aware of the specific research evidence about the links between alcohol and crime and/or anti-social behaviour and assume the unit will be taking advice from specialised agencies. However, anecdotally, it is clear to us that alcohol results in behaviour that leads to criminal activities (drunken destruction of property for example). It is implicated in many fights in local pubs, and plays its part in domestic violence. To define 'anti-social' behaviour is problematic and is dependent on the perspective of the viewer. What is seen as anti-social to a group of twenty year olds will, in all probability, be different to a group of fifty year olds, with each point of view being equally valid. Furthermore, definitions of anti-social behaviour are, to some extent, dependent on cultural norms. This needs to be taken into account on any strategies that are implemented.
24. To respond to this question would, for BAPCA, be outside its knowledge base and would simply be anecdotal. One reason for this is many of our members work in voluntary agencies that offer counselling, which is an activity not easily integrated with fact finding research. Although there are research protocols that can be adapted to the counselling/therapeutic environment, put quite simply, most voluntary agencies do not have the resources for such levels of research. This is a glaring hole in the gathering of information regarding problem drinking and its effects which should be addressed by a national government strategy.
25. It is always difficult to distinguish between perception and reality and there are many who would argue that, for the individual, perception is reality (cf. Rogers, 1959). Certainly the image of rioting football supporters is often

shown as having originated in the pub. Many people will have experienced criminal and anti-social behaviour around pubs and clubs, particularly at closing time, thus fuelling the perception that alcohol is a major factor in all such behaviour. We are not convinced this is accurate in terms of overall levels of criminal and anti-social behaviour and it would be inadvisable to lay all these ills on this particular doorstep. Whilst it is a hackneyed and seemingly unfashionable view, we believe that an aspect of criminal and anti-social behaviour includes social and psychological deprivation. Such deprivation may or may not lead to alcohol mis-use. It is important not to lose sight of this facet of such behaviour.

26. It is clear to us that there needs to be provision of community meeting places as alternatives to the local pub. It is rare that new housing projects include any community areas, particularly in urban areas (unless they are a part of 'gated' housing projects). Planning permission for such projects could require such areas. Although this is currently the responsibility of local government, national government lays down the criteria and the guidelines.
27. We are not sure that, in the final analysis, impact on rural and urban areas is much different. However, it is worth stating that most of our members live and work in urban areas. It is possible more 'at home' drinking takes place in rural areas than urban areas. Nevertheless, the issue would be how to combat problem drinking in the home regardless of the wider environment.
28. Although BAPCA is not an environmental designer, there are some designs we can see that could lessen the impact on the environment. Some obvious examples would be the provision of more public toilets, more litter bins, easier access to public and private transport. Additionally, the design layouts and use of materials in pubs and clubs could be considered. Most new pubs and clubs are big, open spaced areas with a hard design which tends to make them noisy and frenetic – dynamics that are conducive to more frenetic drinking patterns. We are not suggesting that these pubs and clubs should not be present, but we are suggesting there should be more alternatives.
29. We are aware of a number of initiatives that bring different organisations together, for example Alcohol Concern, the London Drugs and Alcohol Network. We are also aware of counselling agencies that have worked with the criminal justice services. We believe that these initiatives should be encouraged more widely and we are aware of many agencies that would like to do that. However, time and time again the problem of resources is mentioned as one of the main reasons that agencies, particularly voluntary agencies, are unable to fund and staff new initiatives nor continue already established programmes. Although there can be inter-agency difficulties, different views on confidentiality for example, the concept of different organisations working together and thus being able to develop services more individually tailored is one we would support.

30. Although it is not clear to us that anti-crime and anti-social behaviour initiatives should be targeted on young people per se, it is clear that drinking patterns developed in late adolescence and early adulthood can set the scene for later life. For that reason targeting the drinking patterns (other than those based on anti-crime and anti-social behaviour) of young people seems appropriate. This is a large undertaking. Those of us who have been involved in youth work over the past ten, fifteen years have seen the decimation of youth provision. Consequently, at an increasingly young age, young people see going to pubs and clubs as the only place to meet and the only pastime available. Alternative meeting venues (alcohol free) and alternative activities are not things they are accustomed to attending. Consequently the eighteen year old who once may have visited a pub/club on a Saturday night and be involved in other activities the rest of the week is now used to being in the pub 4/5 times a night. If this is too expensive, having found alcohol to be pleasurable, alcohol is drunk at home, or on the street. This is very clearly an area where the government has and role *and* a responsibility in funding initiatives that offer an availability of alternative leisure activities to young people. This would address both current criminal/anti-social behaviour and influence future drinking patterns.
31. There is a group of people for whom drinking is associated with set hours and set places. The proposed change to licensing hours acknowledges this situation and may go some way to alleviating some of the problems associated with people drinking as much as they can before eleven o'clock. This could be extended to include freer availability of alcohol in certain settings. This would encourage the learning that alcohol can be a pleasant accompaniment to an activity rather than an activity in itself. This, in turn, would reduce criminal and anti-social behaviour. We need to remember that in itself alcohol is not a cause of criminal and anti-social behaviour. Rather, for a large percentage of the population, it is the amount that is drunk and the rapidity with which it is drunk that is the problem.
32. Existing controls and powers do go some way to tackling the problems associated with alcohol use. However, as is usual, the controls are only effective in the area they are implemented. The difficulty is usually just moved to another location and does not tackle the underlying problems. It is our position that whilst it may be appealing to develop further laws on public drunkenness etc., this is only a short term solution. Crime and anti-social behaviour is more productively tackled through education, healthier drinking campaigns and, particularly in respect of young people, the provision of alternative activities. These are long term solutions that need government commitment and resources.
33. Principles that guide the balance of individual rights and responsibilities need to rest on the idea that most people do not wish to be anti-social nor criminal. We wish to emphasise that when peoples' basic needs are met, and they are living free from physical and psychological threat, they tend to behave in a way that recognises that their own well-being is interlinked with the well-being of those around them. Conflicts of rights can often be resolved through discussion. Therefore, underpinning a balance between rights and

responsibilities is the need for a fair and just society. Approaches to problem alcohol use will fail if they do not consider the wider social context in which they occur.

This does not mean we sanction any behaviour from an alcohol user. A further guiding principle needs to be the protection of the social and psychological space of the community.

One of the difficulties in developing principles to guide the balance of individual rights and responsibilities is the physiological effects of alcohol itself. Alcohol is a depressant drug and affects the ability to assess risk. Whilst a person is sober their understanding and agreement to a set of principles regarding rights and responsibilities may be very different from when they have had a drink. Drink-driving is a very good example of this. The vast majority of people would agree that drink-driving is not acceptable. However, many people who have been drinking, drive. Many people, who agree that drink-driving is not acceptable, get into cars as a passenger with someone who has been drinking.

Therefore, as a further principle, we suggest that when someone has over-consumed alcohol, they relinquish certain rights because they no longer are responsible. This principle rests, in part, on the additional opinion that the government has the responsibility to continue to offer and develop information and advice on the effects of alcohol. People need to be given the facts on the effects of alcohol, both social and psychological in order to fully understand and, most importantly, act responsibly. This education needs to be long-term and sustained.

34. Perhaps one of the greatest lessons that can be learnt from drink-drive policies is that they take a long time to enter personal consciousness in terms of behaviour change. Short-term this is somewhat depressing. However, it is clear that drink-driving is now considered by most people to be not simply criminal in that they can be arrested, but also anti-social in that it is now a morally questionable behaviour. The campaign has been long term and fairly consistent. Latterly, it has also been non-sensational – simply giving the facts related to drink-driving. It is these factors which we believe to have been significant in its success.

35. It is difficult to specify the nature of the link between domestic violence and problematic alcohol use and it is tempting to concentrate solely on the alcohol use. Perhaps it is stating the obvious to point out that many people who have problems with alcohol do not have problems with domestic violence. Given the physical and psychological effects of alcohol as a drug, it is unsurprising that any tendencies toward violent behaviour will be exacerbated in the intimate environment of the home. Once identified as a problem, good practice would include exploration of the underlying issues that are resulting in the violence. This may mean individual, couple or family counselling/therapy. We emphasise that this intervention needs to be in response to the individuals/families stated need. We do not see it as conducive to behavioural change to force people into services that others have identified they need. Whilst there may be some circumstances where there are issues of co-dependency (i.e. the family system supports the problem drinking) it is clear that this is not the case in all situations.

The Implications for Vulnerable Groups

36. We see all children and young people as being vulnerable to the consequences of alcohol mis-use. Often, sometimes out of a sense of protection and even shame, they will not talk of problems of alcohol mis-use in their homes. We do not see it a useful to isolate the vulnerability of children and young people through alcohol mis-use from any other vulnerability. Children and young people need access to people/services where they feel able to disclosure any problems they may be having.
37. Other groups that are vulnerable include immigrant groups who are facing isolation and a complete dis-integration of all they have known. In these situations use of alcohol as a short-term coping mechanism can become a long-term problem. We believe that any Page: 15 [0]individual who finds themselves isolated, without family or some kind of community are particularly vulnerable and at risk from the harmful effects of alcohol. Therefore this includes people leaving institutions, particularly residential care, prisons, working men and women who are made redundant and people leaving the armed forces.
38. A key factor that requires understanding is the need of people to feel psychologically safe. This includes physical basics such as housing, warmth and enough to eat. The need to feel safe should not be underestimated and much behaviour can be traced back to this fundamental physical and psychological need. Thus, whatever practical interventions are made short-term, we ignore this long-term aspect of alcohol mis-use at our peril. Interventions need to be sustained and consistent. Another factor that needs to be understood is the motivation present when a person presents as in need help. As pointed out above, this is the most significant factor in enabling a person to make changes in their life - in this context, to changing their drinking habits. Six month waiting lists for services do not harness a persons' motivation and government interventions should be aimed at helping to improve the response time of statutory and voluntary agencies.
39. We assume that those agencies with direct experience of joined-up services will be able to respond to this question more specifically than BAPCA. However, general responses from our members indicate that two of the main difficulties that get in the way of joined-up services are lack of resources and lack of understanding between services.
- Lack of resources: Joined up services require time and commitment from those involved. This is in terms of attending meetings, initiating projects, following through those projects and monitoring the effectiveness of new services. All this costs time and therefore money. Many voluntary agencies are already living a hand to mouth existence and simply do not have the resources to take on new initiatives – or indeed continue established projects.
- Lack of understanding between agencies: As there are different understandings as to the aetiology of problem drinking, so there are different understandings

of the best approach in helping those people with drinking problems. We do not believe that it has been shown that there is one 'best' approach. However, lack of understanding on how agencies work sometimes leads to dis-jointed service provision at best. At worst, it leads to competition rather than cooperation. Again resources are needed to support agencies to overcome mutual ignorance in order that a wider range of services is more comprehensively offered.

Additional to the above, comments from our members have also stressed the need for local 'joining-up' rather than just national or regional co-operation. Again resources are needed for these initiatives.

40. We feel it is unrealistic to expect all individuals to fit in with what are currently mainstream (statutory) services. It is also unrealistic to expect mainstream organisations to be able to respond to the wide range of individual needs. This puts unmanageable stresses on organisations and individuals within these organisations. On the one hand this leads to burn out and high staff turnover. On the other hand, it can lead to services that are offered in a non-flexible manner thus defeating their aim. Consequently, both for service users and for the health of service providers, services need to be tailored to individual groups and, as suggested, on a case-by-case basis. Having said this, it is our experience that many people do benefit from mainstream services and we would not wish to imply that their work is not beneficial. Nevertheless, we are also aware of many people who do not benefit from these services. Our experience suggests that if services can be more individually tailored the likelihood of successful outcome is increased.

Education and Communication

41. In line with much of the above, the aims and objective in this area should be to inform and educate people of the effects of alcohol and the possible outcomes of alcohol use – both positive and negative. Such information would also include how behaviour influenced by alcohol changes.

It is worth noting that the safer sex campaigns (HIV/AIDS) of the early eighties were spectacularly unsuccessful. They gave no clear information on routes of transmission and used fear to try and put people off unsafe sex. As a result, if people thought it had anything to do with them, they changed their behaviour for a short time, and then reverted to old, unsafe behaviour. Fear does not change peoples' behaviour over time.

On the other side, the drink-drive campaigns have, over time been successful. Based on a consistent message, consistently given, they have not needed a sensational approach to work. This is also evidence that, long-term, anti-smoking campaigns have been successful with some population groups. This seems to be a result of a flood of information about the health risks, a ban on advertising at cinemas and on television, and an increase in Quit smoking agencies. Smoking has become generally regarded as an offensive activity as evidenced by so many areas where smoking is not allowed. As previously stated, sustained effort from a variety of angles is needed to effect change in behaviour.

42. It is clear that health promotion campaigns have worked and evidence can be found in the reduction in specific activities – smoking for example. We are aware that such campaigns do not work in isolation; they need to be supported by appropriate services. Later safer sex campaigns were effective as measured by the slow down in sexually transmitted diseases. However, this slow down was soon lost as the safer sex campaigns were dis-continued.
To assess the effectiveness of health promotion concerning alcohol would be relatively easy. Research into the numbers of alcohol related injuries for example would be a very clear indicator of effectiveness.
43. It is our opinion that the sensible drinking message is not reaching a very large audience (other than drink-driving). Levels of sensible alcohol consumption are seemingly confused. Further, it is difficult to assess its penetration or its effect on behaviour. Anecdotally, some people in their homes seem to be aware of managing their alcohol levels to suggested amounts. However, it is clear that for many people, perhaps particularly young people, the message concerning the dangers of ‘binge’ drinking have not got through.
44. It is not clear to us that scientific research is feeding into alcohol education, nor is it clear to us that its message is based on sound, unbiased and uncontroversial research. In respect of service provision, much of the research seems based on small groups in treatment agencies/centres. We are not aware of any major government backed research taking place in alcohol or alcohol and drug *counselling* services. In consequence, current research has serious limitations regarding the outcomes of different approaches to problem drinking. Therefore, new findings are from a particular viewpoint (a medical model) and cannot be effectively incorporated to services not based on that model.
45. We do not feel that particular groups should be targeted for information and communication. Alcohol use exists within a wide cultural context and, on this larger scale, society as a whole needs to re-evaluate its relationship with alcohol use. Rather, we believe that information should be customised for different groups. For example, the message to men will not necessarily be received by women in the same way – including detrimental levels of drinking. This is also true of some Asian communities where it has been shown that alcohol tolerance levels are lower than in the larger community. The danger of providing more intensive alcohol education to groups other than young people is that those groups not targeted do not realise this can also be a problem for them.
We also believe that alcohol use needs to be viewed within the context of drug use as a whole. The dangers of alcohol use needs to be connected, and considered, along with the dangers of other drug use (e.g. cannabis, heroin) thus engendering the same caution in people as is currently more likely when they consider illegal drug use.
46. Schools, colleges and the like have an important part to play in providing alcohol education as these are the ages when people can lay down quite significant and deeply held behaviour patterns. They can be the first point of

contact for a young person worried about their drinking patterns and therefore are important, and most appropriate, as support for alcohol-related problems. Healthy learning environments need to be non-judgemental and accepting of different individuals' abilities and needs. To this end, and in respect of alcohol related education, establishing and preserving such an environment means having staff with the ability to work with people who are not 'following their advice'. It means that the education is open and for all – not just those identified as 'at risk'. Perhaps, most importantly, time and resources need to be given to such initiatives. There is no point in simply adding to current workloads. This will, quite understandably, lead to dissatisfied staff which leads to dissatisfying services.

47. The model of behaviour seen in the home is another significant influence on the individual's belief systems and understandings of the world. Children often learn more from what they see rather than from what they are told. Families and significant carers need information and education to help them with their own responses to alcohol – problematic and non-problematic. They also need support in finding ways to help their children on the issues of alcohol use (and drug use generally). Many agencies, statutory and voluntary, could play a part in this type of support. Specifically, schools could offer seminars for parents and care-givers. For people to be engaged, these activities need to be offered in ways that free from judgement and are experienced as supportive rather than punitive. Alcohol and drug services are perhaps not best placed for such work given that currently they are usually associated with alcohol being problematic – something that many people may avoid. Having said that, for people already in contact with these agencies we suggest that couples and family work could be increased and include parenting issues concerning alcohol use.
48. Experience shows that there is no one way that is most effective of getting a message across. Different groups have at their disposal, and respond to, different mediums. It is clear, for example, that young people are far more technologically minded than any other group. Thus, the medium of the internet, text messaging and electronic games will be an effective medium. Other groups respond to different approaches and each one needs to be targeted based on past experience. Paradoxically, as the relationship between the government and the alcohol industry is seen with some suspicion (the government raising taxes from alcohol sales); the government is well placed to be successful in healthier drinking campaigns. However, the government is sometimes seen as quite distant from many people and can be experienced a 'preaching from on high'. For this reason local information campaigns would also be needed. An added advantage of this is that local campaigns can be tailored more specifically to the local population.
49. Educational initiatives in the field of illegal drugs showed that such initiatives could influence drug taking behaviour. It is clear that some people did/do not take drugs and some people were able to use drugs more safely. These educational initiatives have been ongoing and, for the most part, non-sensational. Local and voluntary educational initiatives have also been of help

– the simple sharing of experiences of the family of Leah Betts has played their part (we refer here to the work of her family rather than the pictures of Ms. Betts in hospital). We also need to learn and accept that there is a group of people that, however high the overall success of an educational initiative may be, will develop and experience problems with alcohol use.

50. The existing regulations of advertising on alcohol continue to allow alcohol to be glamorised and to be seen as something desirable. There is an argument for suggesting that alcohol should be treated with the same caution as other mind altering drugs and this would imply a total ban on all alcohol advertising. Perhaps it is more realistic to suggest that alcohol advertising should be approached with at least the same vigilance as is now the case with tobacco advertising. This would include the regulation of product placement on TV and the sponsoring of specific TV programmes (for example ‘Sex in the City’ which is ‘sponsored by Baileys). It may also include regulation of magazine advertising. Clearly this requires strong government will and commitment. We do not underestimate the power of the alcohol industry.

The Shape of the Market and Market Based Solutions

We feel that questions 51 – 61 are beyond the remit of BAPCA.

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