# National Alcohol Harm Reduction Strategy Consultation Event

## Health: Prevention, Treatment and the Impact on the NHS

**14. How do you define harmful drinking?**

Mostly as defined by World Health Organisation but the Portman Group have also provided additional interpretations. Government provides guidelines relating to adverse consequences - friends, relatives, work colleagues. British Liver Trust identify moderate levels for their patients. Community Safety definition. It should always be recommended that alcohol has different effects and consequences for different groups of people within society. Individual perceptions of harmful drinking vary which was not helped when the definition was changed from 14 & 21 units then changed to 21 & 28 units - confusing?

**15 How clear is the evidence both for the health costs and the health benefits of alcohol?**

Evidence for alcohol seen to be clearer than for illegal drugs - bigger evidence base regarding health costs. Benefits related to cardio-vascular disease (J-shaped correlation) identified but not so with other diseases relating to evidence of health costs. Research is often undertaken in isolation - in other countries may be heavy costs of drinking where costs may be interpreted from a different perspective.

There is an overriding feeling that there is very little education on alcohol issues compared to that of smoking. No Government warnings. Need to consider other aspects such as diet, support, climate, family life etc. when considering harm - all are relevant.

There is a need for more local based research and evidence - especially more relating to costs. Little information exists in relation to alcohol use within different cultural and ethnic groups. More information is required about schools alcohol education work - what is being done? More information is required on the ground, systematic data collection - police, hospitals, agencies etc.

There is a genuine feeling that more treasury cash from duty on alcohol should be focused toward treatment.

**16. What are the costs for the NHS both directly and indirectly due to alcohol?**

Plenty of evidence, harm to drinkers - physical and psychological violence diverting resources from other cases. Clear message around alcohol to reduce drinking - only slight reduction can reduce costs. Unfortunately, it is widely known that some medical staff use alcohol excessively. Lack of resources (detox/treatment) and resources often used ineffectively.

**17. What do you consider to be the most appropriate means of prevention of alcohol dependence and serious alcohol misuse?**

ID for underage drinkers, education, try to avoid scare mongering. Restriction on alcohol advertising and/or health warnings. Alcohol brings in money from sponsorship,

Government revenue - added barriers. Prohibition in USA failed. Raising taxation levels will increase smuggling - which proves can't be done in isolation. Alcohol is price sensitive and the messages in relation to how young people learn how to drink is not positive. Subsidising soft drinks is seen as a positive way forward to encourage young people to drink less alcohol.

More education required to identify who's more at risk e.g. people with alcohol misuse in families. Bars should provide food (not just salted snacks) and the cost of snacks should not be at highly inflated prices.

Value workers in services more as it is identified as a hard field with poor pay. Messages could be relayed on soaps (TV). Education - learning by a positive example. Opportunities - need to be better for all of society. ID cards, unit marking, labelling, informed consent.

There was a consensus view that there is little need to re-invent a wheel when good practice already exists.

**17. 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 lot of education around illegal drugs and not alcohol despite fact that far more people drink. A tiered approach would be helpful as there is very little alcohol training for social workers despite the number of clients with alcohol problems. Information on accessing services is required. Unless specific interest exists in medical profession, very little training on alcohol is provided, even in psychiatric profession.

Training is currently poor around addictions. There has only recently been a slight improvement, with some information in medical journals. There are different levels of assessment and referral, with training around brief interventions required. Booklets/directories need to be available detailing services etc, whilst they are currently available they still remain hard to obtain.

Module/s on substance use for all health/social care courses "Why do people drink?"

**18. How well have you found 'brief interventions' to work and how might they work better?**

Added value if record work done and plans of care models. Cycle of change - more for alcohol use as in as in smoking - resources needed. Need more up to date videos, literature. Brief interventions generally expect GP's, Doctors and nurses, who have little time or experience, to do this. This results in unsuitable, inappropriate and ineffective interventions occurring, which may put patients off returning for treatment and/or support. Efficacy also depends on patient's current health status. Lacking systematic approach nowadays. Needs social pressure too as in smoking situation - social changes. Access of different communities into services varied.

Identification needed for at risk people in different areas of workplace. Need to raise awareness for staff before problems arise. A & E wards, schools, tier 1 services. Those at risk not clearly identified.

Effective, small amounts of information in a short amount of time focus on one issue - people respond well to a brief session. Some people will not respond well or attend long-term therapy.

**19. Do current treatments for alcohol dependence and hazardous drinking work?**

Individual has to want help and be determined to change (How do we define ‘work’?) Lack of money to buy services that evidence base shows to work. Need to provide aftercare. Is problem viewed seriously enough? Efficacy depends on how well needs can be met. Dual diagnosis - alcohol and mental health ‘big problem’ - there is a total lack of services. It is very expensive to provide services for dual diagnosis - there are more in the South. Mental health difficulties can be at different levels and should be preceded by needs assessment and treatment. Education needed for specialist services who don’t know much about alcohol and addiction.

Support usually needs to be individually tailored and capable of intensive long-term. Skills based training for drinkers is required. Insufficient services for women, BME and other minority or excluded groups.
Why not incorporate alcohol into the 10-year drug strategy? Push for cross-governmental strategies.

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

**21. 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?**

Long term - changing culture and reducing binge drinking.
One current trend that needs addressing and changing - bars/pubs changing layout from tables and chairs to standing room only and playing loud music; this is reducing conversation, and encouraging drinking (if your not talking your drinking). Create a real 24-hour city (transport, shops, whole life of city) to increase natural surveillance and dilute effect of rowdy minority.
Edinburgh, New Year's Eve - free bottles of water distributed to people, no glasses allowed (plastic only)
Manchester - bottle banks on streets reducing numbers of discarded bottles, which may be used as a weapon. Shatter proof glasses part of license requirement for premises.
Quick exit from city - more late night buses, better and cheaper taxi service.
Eliminate or reduce numbers of glass drinking vessels - link to granting of licenses.
Stringent alcohol policies in workplace. Help and support not punishment.

**23. What evidence is there about the links between alcohol and crime and the links between alcohol and anti-social behaviour?**

Anecdotal and visual - Leeds City Centre at 2:30 am. Areas around shopping parades with off-licenses selling to under-age drinkers. Numbers of door staff employed. CCTV. Social and medical tests on offenders. Assessments for youth offenders include alcohol. Victim studies for domestic violence - post event.

**24. In your experience, is alcohol a factor in habitual re-offending?**

A person's drinking patterns set from early age. Life chances or lack of them affect habits i.e. exclusion - excessive alcohol consumption leads to vicious circle of criminality, which may not have happened if exclusion had not occurred.
There is evidence of people committing acquisitive crime to feed drug habit, but lots of re-offenders cite alcohol as an issue. Many drunken offenders do not get into criminal justice system as it is not seen as great an offence as drugs (drugs are illegal, alcohol is not)

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

Age of offending is rising. Initiatives should focus on those who cause the problem, not necessarily under 17 year olds. Quite often over 30 year olds cause as many problems.

Peer group influences on young people should be targeted. Also education for parents, carers and adults in a position of responsibility.
It is an opportunity for prevention and harm minimisation. A start to change culture.
Education should start at an early age - formal citizenship, education at school plus informal such as television, friends & family plus peer support.

Older people should also receive some type of information.

**27. What are the differences between urban and rural drinking patterns and how do they affect those communities and surroundings?**

Urban - people rarely live in area they drink in so have no ownership of area or respect. Rural people may seem better behaved than urban albeit this cannot be evidenced. Rural - drink driving may have affected the amount of people using village or rural pubs. Some become 'Wacky Warehouses' which encourages family centred activities to the detriment of traditional pub culture.

Some pubs in villages and small towns have very high levels of disorder associated with drinking. Many pubs (especially with small communities) have many young people misusing alcohol due to pubs not enforcing under-age drinking regulations.
Some rural areas have bigger drug problems than alcohol related ones.
Young people often struggle to identify with traditional rural values and traditions (fox hunting, community, Church etc)

**32. How can the law on, and policing approaches to public drunkenness and street drinking help to tackle these problems?**

Concentrated, visible policing in hotspots can lead to people 'playing up' to the police.
Some changes in legislation have become totally accepted in our society such as seatbelts, drink driving regulations etc.
No drink zones should be utilised more. Location of drinking and late licenses - not in residential areas etc

**34. What can we learn from drink-drive policies?**

A determined long-term campaign can work. Must be supported and seen to be supported by those at a senior level. Long-term funding initiatives can act as an incentive. Quick fixes will not work. Look at good practice and what worked well. For example, most people accept that smoking at work is not to be tolerated, how did that work?
ID has mixed benefits. Responsible drinkers - pay more for drink, get a better quality of service and better environment, leads to long term financial benefit.
Evidence of efficacy is long term. More police traffic resources needed. Possible zero tolerance for drink driving or increased penalties.

## The Implications for Vulnerable Groups

**35. What in your experience, is the nature of the link between domestic violence and alcohol misuse?** (either by the perpetrator, or, by the victim)

Drinking often occurs cope with situation at home. Drink is evidenced as a very common reason for domestic violence. It is an issue of males drinking and perpetrating violence towards women. Is there actual evidence that our awareness of domestic violence has increased?

Alcohol is used as an excuse, it is not a reason, probably because it is socially accepted. Alcohol is an additional domestic problem to a violent partner. It is used as a disinhibitor. Domestic violence has many causes and reasons, alcohol often comes out on top as the real issue. Alcohol affects issues that impact upon domestic violence.
Causes of domestic violence are separate from causes of alcohol.
Domestic violence may be exacerbated or fuelled by alcohol use.
Domestic violence may lead to alcohol use by the victim and/or perpetrator.

**22. What are the links between alcohol misuse and mental health problems?**

Alcohol is often used as self-medication for depression and anxiety. Excessive alcohol usage is linked to childhood trauma - violence, mental unrest, early dementia and psychological trauma.
Dual diagnosis - Is the alcohol misuse a result of a mental health problem (depression, anxiety etc)? Does alcohol misuse cause a mental health problem? Why can't treatment/rehab centres be cyclical? Need for care co-ordination is urgent.
Can lead to problems such as Wernicke's encephalopathy and Korsakoff's psychosis.

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

Children whose carers use in the home. Socially excluded and/or isolated, those excluded from school. Children from higher socio-economic groups to those young people who have offended. Children of drinkers who also drink. Children in care.
Children and young people released from social, cultural and religious constraints.
Young people who don't associate themselves with typical 'drunk', or 'alcoholic'.

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

Street-sleepers. Older people - this is an ignored problem. Lesbian, gay, bisexual, transsexual, transgender etc people.
Refugees and asylum seekers. People in employment under stress. Those ignored groups - such as people from religious/cultural groups that may have a problem but do not come forward due to taboos and constraints.
Isolated and/or marginalised women - plus anyone isolated from life events.
Armed forces.
Hepatitis B & C positive people. Those denied access to services.

**38. What key factors need to be understood about those who are vulnerable to the consequences of alcohol misuse who often have complex problems for example homelessness and mental health or drugs problems?**

We need to look at the whole picture - income and employment levels. Some people like drinking and don't want to stop. Availability of alcohol - we have created a 'binge drinking' culture due to restrictive opening hours. We don't encourage people to drink safely.
Some services may not be perceived as relative or accessible. Services need to be pro-active and multi-disciplinary. Holistic, client-centred approaches appear to show better results.
A common assessment process that encompasses all issues and needs of client is required.

**39. How can the services provided by the state and others to vulnerable groups with complex problems be joined-up most effectively?**

DAT role is crucial, multi-agency approaches are best but there is still a long way to go. Staff. Professional training - confidentiality, shared information, knowledge of other services to drug and alcohol services. Communicating, shadowing other workers from other agencies, seconding care co-ordination. Universal structure cannot work due to eclectic mix of clients.

**40. 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?**

'Models of care' needed for alcohol. Street drinkers need tailored service - their needs are different. Services should co-operate more effectively - co-operation not confrontation. DAT's should lead on strategies.
Students need student services. Women centred services. BME services.
Homelessness agencies need to access one another's services with integrated care co-ordination.
Primary care is key access point within communities.

## Education and Communication

**41. What should be the main objectives of education and communication?**

Dependant on age and culture. Young people need all of awareness, information and culture change. Advertising seen as the main proponent for poor drinking culture. Advertise the unit volume on bottles etc. Shops and off-licences still too easy to supply to young people. The idea of drinking being the social thing to do is still very predominant.

The 'don't do' message doesn't work. Effective training materials include CD ROM (for 10 - 14 year olds) takes them on a virtual tour of a club/pub and explores lifestyles of people on the disc. Messages should be about sensible or minimal drinking and informed choices. More enforcement needed to stop young people going to places where they know they can buy alcohol - shopkeepers, pubs that serve under 18's etc.

**42. What is the evidence on the effectiveness of these approaches when applied to specific objectives?**

We know the 'just say no campaign' didn't work. Drink driving campaigns were successful and is now part of social conscience that it is unacceptable. Smoking campaign - shock tactics good for adults but not for young people.

**43. How well is the sensible drinking message reaching its audience?**

What is sensible and who decides it? Bar-staff rarely refuse service to young people. How many licensees actually lose their license as a result of this? Should be more 'test purchasing' i.e. sending trained 'customers' (who are under 18) into pubs to attempt to purchase alcohol. Message isn't really working, what is 'sensible' message? Units do not explain 'sensible' drinking, as they do not talk about different health aspects, lifestyles etc. No balance between harm and alcohol being good.

**45. Should particular groups be targeted for information and communication?**

Licensees, door staff, workplace policies. Transport industry, building trade, GP's. More culturally based education (BME)

**46. What is the role of schools, colleges, universities and other educational institutions in providing alcohol education as well as support for alcohol-related problems?**

Continuation and consistency - schools should not work in isolation but all deliver the same quality and type of session. Should start pre-school, throughout school and into adult life. Parents need to accept their own use and patterns of use. There are enough agencies in Leeds that could deliver targeted training to relevant people i.e. medical students, A&E etc.

**48. What does experience show on the most effective means of getting messages across?**

CD ROM, multimedia approach. Alcohol free nights in clubs for young people. Brief health interventions at Health Centres offering totally anonymous intervention, sign posting etc.

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

There should be regulation of advertising and health warnings on drinks. Should get companies that make or sell alcohol to make educational adverts. Introducing age limit of 21 years not a good idea. Harm reduction initiatives face up hill struggle, for example, a young person on a night out will be bombarded with glossy leaflets promoting cheap drinks and drink offers, whereas drug and alcohol services do not have the equivalent (or even near equivalent) funding to do the same.

## The Shape of the Market and Market-based Solutions - The Economic Costs and Benefits of Alcohol

**52. What is the relationship between the creation of trends and fashions in alcohol consumption by the market and consumers responding to trends and fashions?**

Breweries in terms of 'product placement' set trends. Producers want people to buy their specific drinks so encourage, through their adverts, that, as opposed to promoting a night on the town. Adverts do promote drinking as a social event that should be enjoyable, they do not promote getting drunk. However, some adverts do suggest that naughtiness or wickedness may be associated with drinking, what sort of messages this tells people about drinking is unclear.

During the late eighties and early nineties the male market had become saturated and peaked and a need to find new customers was evident. Therefore breweries needed to develop a drink that would appeal to a market that had not previously been the main target of advertisement; women. Alcopops filled this gap. Research tells us that most people who drink alcopops are aged between 18 and 30 and are women. Contrary to popular belief, young people do not select alcopops as their drink of choice; they tend to drink cheap cider or strong cheap lager, which you will rarely see, advertised on television.

Closely linked to this is a decline in the sale of spirits. Breweries therefore needed to create a new type of drink that still sold a spirit brand name but that was not associated with the traditional style of spirit drinking. The number of different types of alcopops is many and varied.

The trends seem to be set by the people who drink as opposed to the breweries. The breweries focus on individuals buying a particular drink. The trends are set by the people themselves, which unfortunately with young people seems to be, 'How drunk can you get?' or 'If you can remember something about the night before, then it was not a good night.' People will go to places that are popular, and that they like, not necessarily cheap. However, pubs that offer cheap drinks or special 2 4 1 style offers may encourage people to drink more than they had planned to drink. Any pub that sells cheaper drinks will be popular with people who look to save money (students, young people, low income). However, if the service is bad, there are fights continually, etc some people will go elsewhere, some will be attracted to it.

Price fixing may be an option - a minimum amount that a drink can be sold for, but would not stop 2 4 1 offers. We are also in a free market and this would affect competition. But ultimately not necessarily stop the problem. It may reduce the numbers of people that are encouraged by special offers, to drink more than they would usually. But it would not stop those people are already have a problem with drink; if people want to get drunk and drink too much, they will find it no matter what. Remember prohibition.

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

The constant promotion and redevelopment of town centre pubs, coupled with proposed changes to licensing laws, threaten to lifeblood of rural and local community pubs. More people are likely to go to pubs in the town centre, because they've been redeveloped, are more pleasant, they are more likely to be open when their local is not, they will attract more people which in turns generates more popularity which in turn attracts yet more people.

Younger people are unlikely to go out every night but will choose to save their money up so that they can afford one night out per week. Up to £50 in one night. This means that instead of going out for 'a couple' a drinks, two or three times in a week, they will go out 'to get wasted' once. This is most likely due to the current culture that is associated with drinking, plus the lack of appeal of their own local pubs. Consider most of the money that is put into new pubs/bars is in the town centre. The Local Authority is also complicit here as they are keen to develop the 24-hour image of Leeds and encourage people into the town centre; possibly to the detriment of other areas.

More pubs are applying for family licenses which suggest hat more places will become family friendly and therefore create a more pleasant environment., particularly out of town areas. However, these are rarely in villages and often are a 'drive to' place, this needs to change so that pubs in the centre, localities, villages and the outskirts are also more attractive to more people.

**54. How best can Government work with the alcohol industry to reach consumers?**

A significant amount of resources are required to tackle the problems associated with problematic drinking and behaviour. If there is no or little extra funding available, this problem will not be able to be tackled effectively. Local Authorities can act where Central Government has not.

The Government needs to work closely with producers (brewers) and apply rules/ guidelines upon them as opposed to the 'self regulation' that currently exists. For example, cigarette packets have warnings on and advertising (in most cases) is banned. The drinks industry does not have such imposition, they can choose to put health information on drinks. Self-regulation has created a situation where some drinks clearly indicate the number of units they contain; this is often supermarket 'own brands'. A mandate from Government would make such notices a requirement.

Government should work with industry to encourage them to produce healthy drinking information (cost implications here). Some pubs have installed computers to provide access to health related websites. Some companies operate a Code of Practice' which relates to drunkenness, under-age drinking, behaviour, drugs etc. This is however a self-regulatory creation, not one the Government has brought about.

Multi-agency working has worked to reduced problems with alcohol misuse, where a licensee has worked with the police and licensing authority to combat problems. This type of multi-agency approach should be used and the Government makes sure that this is a requirement. In the same way that DAT's are made up of a variety of organisations, so to should the groups that address alcohol issues. The groups must include representation from the across industry, this means the people who produce alcohol to those that have responsibility for selling it and licensing it.

It is also important to 'think outside the box' when considering who is involved with Community Safety Partnerships. Transport, licensees, communities, entertainment's etc are groups that should be included. There are big concerns that public transport is inadequate. Frequently on a late night many people are unable to get home cheaply (if at all) and therefore cannot go out regularly but have to save up for one big night out - taxi's can charge excessive rates. If you live 15 miles out of town, this will add at least £20 to the cost of a night out. Some taxi companies charge double or even treble time to gullible youngsters. Do we include taxi companies when addressing alcohol issues? Consider, Magistrates refusing a license to an establishment that refuses to stock glasses that shatter into tiny harmless pieces as opposed to shards of glass. This is a community safety issue that pubs, clubs and restaurants have a duty to be involved in; at the same time, one should not criticise pubs, clubs and restaurants for not doing enough, when we continue to exclude them from any discussions.

**56. How clear is the evidence both for the wider economic costs and benefits of alcohol?**

We know that many people are employed directly and indirectly through the industry. This includes producers, distributors (pubs, clubs, restaurants, off-licenses, hotels, sports clubs, supermarkets etc) bar-staff, cleaners, chefs, marketing, drivers, chemists, door staff, taxi drivers, etc… This tells us that it is an important part of the economy. Traditionally, many rural areas rely on pubs as a focal part of their community, generating a sense of well being. We do know that there are financial costs to industry.

It is important for people especially 'anti-alcohol' groups to remember that the industry is there to make profit, they are accountable to share holders and directors of business. Ultimately people's jobs and livelihoods are involved with the industry. Policing of drinkers in pubs etc is a difficult task. Bar work is a difficult (often thankless task) and although staff do have responsibility to monitor customers, this is unrealistic if you have a very busy bar.

**57. Are there any obvious limitations we should be aware of?**

Resources. Who has responsibility? The Host could adopt 'Host Responsibility' schemes - providing water, food, taxis. People will always drink, and some to excess. The industry will be unlikely to bring in initiatives, adverts, new policies that will affect their sales adversely or put them in a bad light. The industry should be encouraged to promote healthy aspects of drinking - possible health links, social well being, community spirit, socialising, integral part of our tradition etc.

**58. What principles could guide us in deciding who is responsible for costs?**

The Portman group used to be able to get leaflets for pubs and clubs etc through the Government, they now have to pay for them. Who should pay for alcohol leaflets? Should a brewery support a leaflet that is effectively discouraging people from drinking their product? This of course makes no economic sense. The emphasis should be on healthy drinking, this would have positive effects for both the industry and the consumers. Those who would blame them for alcohol problems would see the industry in a more favourable light, and this would encourage more sensible drinkers to establishments including families etc. Customers could also have reduced health problems, live longer (drink longer into older age?) The industry could sponsor alcohol-

related agencies by assisting them to produce health-related information - this could create conflict, compromise or agreement.

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

Mainly incorporated into workplace policies and linked to occupational health options. Some organisations have effective health support some do not. 'Drugs in the Workplace' pack is good but only effective if used to reach as many people as possible. Information can be circulated in leaflets and newsletters. There are some but not many. Most policies focus on disciplinary action as opposed to actual support and possible treatment.

**Initiatives designed to tackle alcohol misuse, some that might also be incorporated into the workplace might include -**

Posters in the toilets (as is done in some pubs)
Leaflets attached to wage slips
Email information shots about alcohol (do people always read them)
Duvet days
Drug/alcohol testing
Drinking water for staff
Pubs to promote water as an 'in-between alcohol drink'