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Received

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J. J.

13 January 2003

Dear Paul,

Please find enclosed the response to the National Alcohol Harm Reduction Strategy consultation document from the London Drug & Alcohol Network.

If you have any queries, please contact me.

Regards

Anne Delargy

Anne Delargy
Chief Executive

LDAN Response to the Government consultation paper on a harm reduction strategy for alcohol

1. Introduction

London Drug & Alcohol Network (LDAN) is the membership organisation for the alcohol and drug treatment service providers in London, offering support and advice to agencies that provide frontline services, and representing their interests.

We have consulted our membership, treatment service providers in London, on the strategy. The major focus of our comments, therefore, will be on service issues and issues that are of particular relevance to London. While we have not sought to answer every one of the 61 questions raised in the consultation document, we have attempted to respond to the areas they cover.

We welcome the Government's recognition of the harm that alcohol causes to individuals, families and communities, and look forward to contributing to the success of a comprehensive alcohol strategy that reduces the damage caused by alcohol, which has been called by the Royal College of General Practitioners "our favourite drug".

2. Elements of a strategy

A national alcohol strategy, established, promoted and funded by Government, should include strands on reducing harm in all the following areas:

- Education and harm prevention, particularly for young people
- Reducing crime, particularly violent crime, disorder and anti-social behaviour
- Investing in a range of treatment services, from brief interventions to residential rehabilitation and aftercare
- Measures to regulate supply, for instance taxation, licensing measures, advertising and marketing of alcohol
- Measures to control use of alcohol in inappropriate situations, e.g. driving at work

3. Mapping the harm

The strategy needs to be underpinned by an understanding of the harm caused by alcohol. The harm to individuals includes damage to health, both in increased morbidity and mortality; alcohol is clearly associated with family breakdown, domestic violence and child abuse and neglect; and communities suffer in terms of crime and disorder and decreased productivity.

Problems caused by alcohol are wide ranging and include health problems such as cancer, brain damage, liver disease, hypertension, dependence, mental health problems such as depression, along with major social problems such as violence, public disorder and nuisance, deaths resulting from drink driving, accidents, injuries, family neglect and breakdown, homelessness and absenteeism from work.

This change was brought about by a combination of stick and carrot, i.e. by education and awareness raising campaigns coupled with vigorous enforcement of the law.

6. Health (Questions 14-22)

The health problems associated with alcohol are well documented and include cancers, brain damage, liver disease, hypertension and heart disease, dependence, and mental health problems such as depression. An estimated 65% of suicide attempts are associated with excessive drinking. In addition, alcohol is major contributory factor in accidents, including 39% of deaths by fire; and 15% of A&E admissions are linked to alcohol. Effects on child health are also well known; as well as direct results of alcohol misuse, for instance low birth weight and foetal alcohol syndrome, the NSPCC estimate that over 200,000 children in London are neglected because of parental drinking habits. (*Britain's Ruin – Alcohol Concern 2000*).

With such a wide range of health-related problems, a wide range of health interventions is needed, from early education/harm reduction sessions delivered in primary care settings as a result of routine screening for alcohol use, through counselling and other community interventions through to residential detoxification, rehabilitation and aftercare. There is ample evidence on the effectiveness of the various treatment options offered by alcohol services, including, for instance, the Project MATCH report in 1998.

This will necessitate a heavy investment in alcohol services across the board, similar in scale to the investment in drugs services over the past years. Learning from the experience in the drugs field, this investment would be most effective if it were targeted on interventions with proven effectiveness such as primary care interventions, community detoxification; holistic approaches including skills training and help with social and housing issues; and both community based and residential treatment.

It should be recognised, however, that, because the alcohol services have had very limited resources for many years, in the first few years the levels of need and dependency among people presenting will be very high. This should be reflected in a service strategy – the services offering the highest levels of support should be funded most heavily in the first years of the strategy.

7. Vulnerable groups (Questions 36-40)

We would prefer to use a less emotive term for this - such as susceptible groups, i.e. people who are more susceptible to influence. Some of the groups in this category are young people, especially young women and young mothers; heavy drinkers; and elderly people. We believe that the Government needs to take strong measures to protect these groups, and this means direct regulation of the alcohol industry's marketing and

10. Economic benefits and costs (Questions 56-61)

Alcohol is widely used and enjoyed in London and it is estimated that 6% of consumer spending in London is on alcohol. The alcohol industry is a major employer and the expansion of the night time economy has provided many new jobs in London.

It is estimated, however, (*Violence Research Project, 2002*) that one in four of the new jobs in the night time economy are in security – in other words, bouncers for pubs and clubs. Violence, disorder and anti-social behaviour are of major concern throughout London, particularly in areas of very high concentrations of licensed premises and comparatively low numbers of police such as the West End. We share the concerns of many Londoners, and of the Metropolitan Police Service, that in granting licences, consideration is not at present given to the number of licensed premises that already exist in the area.

Along with the Met, we believe that the extension of the licensing hours will probably exacerbate this situation; although there is little evidence yet on effects of changes in licensing (and more research is needed in this area), we think it is likely to lead to increased consumption by all drinkers, from light to very heavy (and therefore will impact on many of our service users).

11. Implementation

We believe that although a national strategy is needed to give a framework and basic guidance, strategies will be most effective if they are implemented at both regional and borough levels. London is famously a city of many villages and therefore each area needs a different approach, but there is ample evidence from previous police operations in dealing with London drugs markets (e.g. Operation Welwin) that local strategies impact on neighbouring areas; that is, that problems can easily be displaced from one borough to another. The strategy needs to give serious consideration to levels of implementation from local Borough/Primary Care Trust/ Drug Action Team level, through sub-regional clusters to regional i.e. a pan-London strategy.

London Drug and Alcohol Network, January 2003