The principles that should underpin the strategy

Our starting point is one of principle. Before considering how best to tackle the problems associated with alcohol misuse we need a clear understanding of why Government should play a role at all.

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

The harm and cost to society caused by alcohol is well documented and as such the Government has a responsibility to reduce these risks whilst at the same time protect the innocent citizens from harm. The UK is a signatory of the WHO European Charter on Alcohol (1995). There needs to be a Government initiative to enable this charter to be taken forward. The contrast with an established commitment to a drug policy is striking and illogical when one considers the far greater damage inflicted by alcohol.

Government has the following functions in preventing and alcohol misuse:

- To influence the conditions of trade in alcohol to ensure that all costs are met by producers, sellers, and consumers.
- To ensure that the benefits of alcohol consumption outweigh the costs to society.
- To ensure that people have the correct information about alcohol content to enable them to make informed choices.
- To achieve the balance between individuals' rights and responsibilities with respect to alcohol consumption when compared to possible deleterious affects on the rest of society.
- To ensure facilities for appropriate treatment and rehabilitation to help those who suffer the consequences of alcohol misuse.

·

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

Reference to Tackling Alcohol Together [Raistrick, Hodgson, and Ritson. Free Association Books, 1999 pp 20-28] will emphasise some important facts in answer to these questions.

2.1 Government has a duty to protect the health and safety of its citizens. Drink drive legislation is one way that government has intervened. Alcohol impacts negatively on the health of the population in other ways and government has a responsibility to take action to prevent or minimise the impacts.
2.2 Governments have obtained significant income from duties on alcohol. Balance of fiscal gain must be considered with negative impact of alcohol on health and safety.

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

choices?

Requires a rational deabte involving all interested parties.

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

4.1 All categories must be encouraged to play a part in the debate at national and local level. Furthermore, it is important to invite views from those who may suffer adverse consequences such as partners and children of excessive drinkers.
4.2 Society as a whole must identify the place of alcohol within it and it is Government's responsibility to coordinate society's response.

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

5.1 Such a strategy should acknowledge the positive aspects of alcohol consumption as well as targeting specific harm associated with particular patterns of drinking e.g. binge and/or contexts of drinking, e.g. drinking during pregnancy; alcohol in the workplace; drink driving; etc.

- Encourage those with harmful or risky drinking patterns to reduce such risks.
- Provision of treatment programmes for those who have suffered harm.

The cultural and behavioural issues around alcohol use and misuse

Alcohol misuse and its impacts play out against a wider canvas of behaviour and attitudes related to alcohol: we need to understand this wider picture in order to understand how to influence and reduce harmful effects.

Questions

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

Alcohol misuse: Persistent use of alcohol over safe levels or in inappropriate contexts, which may, if sustained, cause harm. Harmful drinking is drinking at a level where psychological and /or physical harm have occurred. There are certain contexts where any alcohol can be described as misuse (e.g. in some work areas) or where intoxication leads to harm of self or to others.

In terms of units of alcohol, low risk drinking for men is up to 3 units/ day, between 3 and 7 units/day is considered hazardous and above 7 units/day potentially harmful. Equivalent figures for women are 2, 2-5, and above 5.

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

All forms of hazardous drinking, but binge drinking, and intoxication, are particularly relevant to public order, community and personal safety.

8. Is there a relationship between trends in drinking and wider social changes – e.g. the spread of higher education, changes in workplace culture, later marriage and/or family formation? Where does this suggest we need to focus attention in influencing behaviour?

More research is required in some of these areas: availability of alcohol as well as the

cost in relation to disposable income is key. The ESPAD report (Hibell et al 2000) findings indicate that young people in England consume more alcohol than nearly all of their European counterparts. Detachment from parental influence at an earlier age may be relevant here.

9. One group we need to focus on specifically is young people, where the evidence suggests a rise in consumption, particularly by young women. Are there other groups we should be focusing on? For example are there specific issues around minority ethnic attitudes to, and use of alcohol which we should bring into our analysis?

The issues surrounding young women include the "ladette" culture exhibited by some professional women in an attempt to keep up with their male counterparts. The physiological affects of alcohol produce disinhibition with its potentially variable consequence (unprotected sex etc).

Some ethnic minorities avoid issue on religious grounds, others are as attracted to alcohol as their Caucasian colleagues.

10. It is easy to focus on the negative aspects of alcohol use and misuse. But what are the positive cultural and behavioural (as opposed to economic) aspects? What parts of our culture would change for the worse if we did not have alcohol?

Trying to disentangle the consequences of the drinking and non-drinking aspects of the activity is difficult because of the intimate links of alcohol with so many cultural activities, e.g. the Working Man's Club; the Golf Club bar; the Officers Mess; the interval drinks at the theatre; etc. There is some evidence that building social capital is good for the health of communities and individuals. Communities that grow up around local pubs and societies contribute to social capital. Increased social capital in such circumstances comes from the interaction rather than the drinking. Such benefits do not occur in conditions where alcohol is consumed in which social interaction is not encouraged.

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

11.1
Regrettably, the best or worst example of the English drinking culture is that relating to football supporters largely because of associated violence and vandalism.

11.2
Legislation has made some impact with alcohol banned on special trains and in football grounds. Problems persist before and after matches.

11.3
Public houses, wine bars, discos, and nightclubs are predominately frequented by younger people: emptying of such facilities particularly on Friday and Saturday night are a well-known part of drinking culture.

12. What factors influence behaviour – fashion and marketing, family background, education and information, financial, legal and regulatory, scientific,

environmental? Which are the most influential in your view? How easy is it to exert influence through those factors?

12.1 Drinking behaviour is determined by individual factors, cultural environment factors and physical environmental factors.
12.2 Individual factors affecting consumption are the individual's beliefs and knowledge about alcohol. Many do not drink because of religious or personal beliefs. Others limit drinking because personal beliefs. Some know how alcoholic drinks will affect them and use this to guide their drinking. Some as a result may drink heavily. Affordability is also relevant: some do not drink because they cannot afford it or wish to use their money for other purposes. Cheap drinks with high relative alcohol concentration are likely to be more popular.
12.3 Cultural environment is a powerful driver of consumption. Those who associate with groups that drink heavily are likely to drink similarly. Vice versa is also the case.
12.4 Certain times of the week are associated with heavy drinking – Friday and Saturday nights.
12.5 If alcohol is more easily available, people will drink more.
12.6 Factors likely to encourage heavier drinking include:

- Lack of social constraints – For adolescents –parents, for men-wives, for adults – children.
- Situation in which heavy drinking is the norm.
- Peer pressure
- A lack of alternatives, high unemployment, boredom.
- Release from a period of restraint e.g. release from prison
- Use of alcohol as a drug of solace
- Reliance on alcohol as a social lubricant.

12.7 Self-perception and social norms may both serve to reinforce heavy drinking. Some heavy drinkers tend to rate their level of drinking lower than others.
12.8 Social trends such as rising divorce rates, later marriage, and later child bearing may all put upward pressure on alcohol consumption levels.
12.9 Rise in importation of cheaper alcohol increase consumption.

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

Heavy drinking, like smoking and illicit drug use is a high-risk behaviour. Often there is a tendency to partake in all three: to reduce alcohol consumption may reduce illicit drug use or it may not.

Health: prevention, treatment and the impact on the NHS

The effects of alcohol misuse cost the NHS money. There are direct costs both to the NHS and in social care in treating those with alcohol dependence. And there are a host of indirect costs through alcohol-related illnesses and accidents; through violence fuelled by alcohol; and through mental illness and depression associated with alcohol misuse; and through the mixing of alcohol with illicit drugs. But there is also some evidence that moderate alcohol use for some groups can be beneficial to health.

Questions

14. How do you define harmful drinking? What factors do you take into account in

deciding whether heavy drinking has become problematic drinking

Drinking that has caused physical or psychological damge to the individual or other. (Figures specified in answer to question 6.)

The realtion between quantity and harm has been widely debated . However some guidance is necessary and it is important that it should be consistent from all sources, and viewed as reasonably compatible with most lifestyles.

. The guidance saying don't drink more than 4 units (3 for women) in any one session is not viewed as compatible with many peoples' idea of a reasonable night out.

The guidance stipulating 21/14 units per week was considered restrictive but possibly compatible with a reasonably enjoyable lifestyle. However, many people do not understand units of alcohol, and those who do "do not think in units". The tendency to underestimate consumption is great, particularly at home where hosts tend to be generous. The previous messages need to be refocused in a way that does not invite adverse comments like "experts got it wrong" or "government changes its mind" type headlines.

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

Attention is drawn to the Royal College of Physicians report, Alcohol – can the NHS afford it? (2001).

This identifies the impact on health and consequently on NHS resources. The evidence regarding impact on A&E departments in particular is clearly defined. The possible screening techniques are described.
Health costs due to alcohol may be caused through intoxication, chronic heavy consumption, or dependency. Health consequences of intoxification are injuries: head injuries, facial injuries, drink driving accidents, etc. Intoxification may lead to acute alcohol poisoning with coma and death. Health consequences of chronic heavy intake are numerous including liver disease (increasing in both men and women, and occurring in late 20s /early 30s, central and peripheral nervous system, pancreas, cardiovascular system (hypertension, strokes) etc. These are not seriously questioned though there is considerable debate over the precise dose response and factors which may modify the risk associated with any level of consumption. Binge drinking is associated with greater risk than consuming in smaller more frequent amounts particularly related to injuries and acute alcoholic poisoning.

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

Several studies have been performed trying to assess the financial burden of alcohol to the NHS. Methodologies differ; however to mention but two studies gives a good estimate. Firstly, the DOH in 1996, Ref 88 in RCP Report 2001, undertook a study to attribute all hospital costs to disease groups. Disease areas considered to have some alcohol-related component included injuries and poisonings (5.8% of hospital costs; neplasms (6.3%); cardiovascular disease (4.2%); and digestive disorders (5%) accounted

for a significant portion of both inpatient and outpatient coasts.

Secondly, the number of acute admissions directly or indirectly related to alcohol was put between 7-40%. Using an average length of stay of 5 days, a 7% minimum estimate of £500million rising to an estimate of £2.9 billion for a 40% maximum RCP Report 2001,Paras 2.35-2.39. These costs reflect inpatients only so that outpatient services are an additional burden. Whichever methodology the costs are considerable.

17. What, in your experience, are the most appropriate means of prevention of alcohol dependence and serious alcohol misuse? What forms of training are most appropriate for professionals in health and social care, as well as other fields, who play a role in prevention.

General societal measures such as reducing availability are relevant to public health. The way that young people are introduced to alcohol is important: peer pressure is equally relevant and encourages some to over-imbibe.

Early recognition of alcohol misuse by Primary Care, Accident and Emergency Departments, and Hospital Staff is crucial and of proven benefit. This requires a serious commitment to training in the basic skills of recognition and early intervention. This should be a priority for investment. The MCA has taken some initiatives in this regard, not least with its Medical Students' Seminars, its Medical Students' Handbook, Alcohol and Health (Morgan and Ritson 1998). Alcohol policies within institutions and businesses are being developed partly as an educational commitment, but also with respect to some health and safety legislation. Literature specifying guidelines on how to deal with alcohol problems within small businesses have also been produced by the MCA

18. "Brief interventions" can be offered to patients who have been identified as at risk from alcohol misuse. They may consist of a short session with a doctor or nurse to discuss a patient's drinking and to offer help and support to cut down on alcohol intake, if the patient wishes to do this. How effectively do you think those at risk are identified? How well have you found brief interventions to work and how might they work better?

18.1 Brief interventions are undoubtedly effective: what is required however is how best to optimise such interventions. Length of intervention, setting of intervention,, and who devlivers the intervention need further consideration. As evidence is gleaned then the best option can be implemented .
18.2 The recent responsibility for commissioning alcohol services having passed to PCTs inevitably will increase the GP's involvement with brief interventions. GPs will need support and cooperation in enhancing their role with the help of the local alcohol agencies and their own practice nurses.
18.3 The internet may have a role to play in the development of brief interventions. Present examples need more sophistication to become consistently effective.

19. Do current treatments for alcohol dependence and hazardous drinking work? Are they sufficiently tailored to meet differing individual needs? Are there other forms of treatment we should be aware of? Is there a need for guidance for the commissioners of local treatment services? How should individuals best access treatment services?

19.1 There are a wide range of treatment programmes ranging from expensive inpatient/residential to less expensive home based low contact. Evidence suggest that

most treatment programmes help most people: relapse is unfortunately not uncommon so that long term follow up is probably necessary in some form or other. Alcoholics Anonymous is particularly helpful in this regard, or similar support groups.

Different programmes benefit different people: predicting who will do better with which programme is difficult. Project MATCH was a big study trying to clarify which programme was appropriate: clear answers were not forthcoming.

19.2 Various principles/ factors are clear:

- A wide range of different services are required
- The present mix of public and voluntary services should be sustained.
- The current level of provision needs to be increased : some areas of the country are better provided for than others.
- No one method of intervention is clearly better than any other.
- Brief interventions are important particularly if there is rapid acknowledgement of developing abuse.
- Home or community based interventions are cheaper and are therefore more cost effective. However, residential service provision is necessary for some patients. Detoxification in the community is an option in some cases if appropriate supervision is guaranteed. Alternatively inpatient detoxification must be available.
- General services including all medical service at whatever level plus social service, probation services, police, and prison services need to be encouraged to engage with people with drinking problems in a coordinated manner. Moreover they need easy access to specialist alcohol workers to support them in this
- AA play a crucial role in the long term support of many people with former or current drinking problems. AA operate outside normal service governance but they should be encourage an supported as acceptable to them.

19.3 The target driven culture of the NHS militates against adequate provision for alcohol as this does not feature in the list of priorities. Better to encourage service providers in the assessment of local health priorities and allocate resources accordingly rather than identify a further set of targets. Drug services have been prioritised ahead of alcohol service despite the greater impact of alcohol: some staff have been withdrawn from alcohol services as a result. Planning of alcohol and drug services need to be coordinated to ensure one is not developed at he expense of the another.

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

That apprpriate resourcing and funding can be effective.

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?

Apply and even regulate what is known about glasses. Improve conditions in public houses and ensure proper server training. This should include more regular refusal by staff to serve people who are clearly intoxicated. There have been excellent studies from the maxillo-facial unit in Cardiff in the last few years considering various aspects of the impact of alcohol on facial injuries.

In the workplace alcohol should be forbidden with the development of workplace policies for alcohol as an issue for Health and Safety at work

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

including depression and suicide? How are services – both those aimed at prevention and treatment – best co-ordinated?

The links between alcohol dependency, depression, and suicide are well known. Better joint working between alcohol teams and mental health services is required. There are training and resource implications here as well as furthering links with social services. Health workers are not immune from such problems and the MCA has collaborated in the production of various reports on the subject, not least The Misuse of Alcohol and Other Drugs by Doctors (1998).

Crime, disorder and anti-social behaviour: the effects on our surroundings and community

The most visible effect many of us see from alcohol misuse is in our town and city centres: pavements littered with broken bottles and streets too intimidating to pass through. Links between alcohol and disorder are as much a matter for concern as are links between alcohol and crime.

Questions

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

24. In your experience, is alcohol a factor in habitual re-offending? Does it lead to particular types of crime? How far does it lead to one-off offences?

25. To what extent can alcohol convincingly be demonstrated to be a factor in criminal and disorderly behaviour? How much is perception and how much is reality? What fuels the perceptions and are they accurate?

26. Alcohol is far from being the only factor in crime and disorder. Other factors are involved – for example town centre disorder can be influenced by lack of availability of transport or design of environment. What other factors might be involved? How easy are these factors to influence? Who is responsible for them?

27. How does the impact of alcohol on urban environments differ from its impact on rural environments? What are the differences between urban and rural drinking patterns and how do they affect those communities and surroundings?

28. To what extent can impacts on the environment (including crime, disorder, noise

and waste) be designed out, for example by use of plastic drinking glasses? Are there examples of good practice it would be helpful for us to be aware of?

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

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

31. Should we be encouraging different drinking patterns – in terms of time spent drinking, location of drinking etc – in order to tackle alcohol-related crime and disorder?

32. How can the law on, and policing approaches to public drunkenness and street drinking help to tackle these problems? Are existing controls and powers (such as those for local authorities to introduce no drinking zones) effective? Are they sufficient?

33. One person's good evening out can be another person's sleepless night. Are there principles to guide the balance of individual rights and responsibilities?

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

35. Domestic violence is often associated with alcohol misuse – either by the perpetrator, or, on occasion, by the victim. What in your experience, is the nature of this link and what would you see as good practice in tackling the interrelationship between domestic violence and alcohol misuse?

A few general comments in response to the questions in this section.

- There is ample evidence linking alcohol and anti-social behaviour. Alcohol is disinhibitory and increases confidence making people more argumentative and more likely to commit acts of violence against people or property (football hooliganism is a prime case in point).
- The potential impact of alcohol on the behaviour of groups of people is enhanced by the numbers involved.
- Proper management of the drinking environment will minimise harm due to

alcohol-server responsibility may help. Premise managers should be encouraged to demand appropriate customer behaviour. Alcohol should not be sold to those who are intoxicated.

· Further information to identify where public order offenders purchase their alcohol may be helpful. Presently it is too easily accessible for under age drinkers. Off licenses and supermarkets are often seen as “soft touches”: soft and alcohol drinks are frequently inadequately separated or differentiated in supermarkets.

· In rural areas, drinking takes place predominately in the home or public house. Some towns have demarcated area in which consumption of alcohol is banned: but how often are these bans enforced?

· The be-all and end-all of selling alcoholic liquor should not be totally related to profit.

· Drinking habits can be learned early in adult life: whilst it is not just young people who behave anti-socially appropriate education at a young age necessary.

· Drink driving policies have generally been successful largely because they are clear and focused on a particular context. Penalties are known and public education is an important factor and the introduction of random testing would bring further improvement. Interestingly and significantly younger people who have grown up with the drink drive policies in place are in general much more cognisant of the facts and less likely to offend. Further consideration to reduce the legal limit even more, probably to zero, is necessary.

· Domestic violence has a very clear link with alcohol: commonsense dictates that a reduction in alcohol misuse will lead to a fall in domestic violence.

The implications for vulnerable groups

Some people may be more vulnerable to the harmful consequences of using alcohol. Certain groups of young people in particular are at higher risk of developing a range of difficulties that include alcohol-related problems (for example children in social care, those excluded from school and youth offenders). Families and carers can play an important role in protecting young people from problems but it is important to recognise that living with a parent or carer with an alcohol problem can itself become a source of vulnerability.

Questions

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

36.1
Children who grow up within families of which one or other parent is dependent on alcohol are at particular risk. The stability of the family may well be affected worth inevitable knock on effects. Moreover, it is known that such children are at risk of alcohol dependency themselves.

36.2
Under age drinking is an issue of concern in UK. The ESPAD Report 2000 has already referred to appropriate use of alcohol is a learned behaviour and thus it is desirable for

children to be introduced to alcohol in a supervised way. Peer pressure inevitably may lead to excessive consumption. However, it is unrealistic to expect children not to drink until the legal age has been reached, and then expect them to drink responsibly.

36.3
Youth offending teams report a link between alcohol and offending behaviour. Home circumstances may encourage alcohol consumption for a whole variety of reasons: no supervision; single parent; no hobbies; boredom; etc. Any offending behaviour may have negative impacts on school attendance, work, and family relationships. There are clear links between alcohol and sexual health. UK has the highest teenage pregnancy rates in Europe: such pregnancies may result from a first sexual experience, often with alcohol as an important factor.

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

Occupations which are known to be at increased risk include publicans and bar staff, the medical professions, lawyers, seafarers, the media, the armed forces, caters, dockers, cooks, and porters. The MCA was originally formed in 1967 to assist colleagues with alcohol problems.

38. Those who are vulnerable to the consequences of alcohol misuse often have complex problems (for example they may be homeless and may have additional mental health or drugs problems) and such factors may be inter-related. What key factors need to be understood in addition to alcohol use that contribute to maintaining the problems facing such groups? Which of these factors should interventions be aimed at?

Indeed some problems are complex and as such an overall view of all the issues is necessary rather than trying to address each issue in isolation. Input is, therefore, necessary from a variety of sources to produce an optimal programme.

39. How can the services provided by the state and others to vulnerable groups with complex problems be joined-up most effectively? Are there examples of joined-up delivery it would be helpful for us to be aware of? What gets in the way of joining-up services?

To provide an overreaching facility to cover all eventualities in all cases is probably not possible but whatever service are involved must be coordinated. Resource availability probably affects joining up of services more than any other factor.

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-bycase basis? What is your experience?

Specific services are available for some groups. The armed forces have, or until recently had, their own.

It is not sensible to expect members of the medical professions to expect to have their

alcohol problems treated within their parent trusts because of confidentiality. That is not to say that such problems be allowed to progress, rather that external facilities be available. Similar support services are used by, e.g., the legal profession.

Education and communication

All of us receive messages about alcohol to some extent. We see advertising for alcohol and respond in various ways depending on our preferences. Information on sensible levels of drinking is also available. And messages on the consequences of getting it wrong can be clear – most obviously for drinkdriving. These are powerful tools for giving information and shaping perception. Do they alter behaviour?

Questions

41. What should be the objectives in this area? Is the aim to raise levels of awareness? Is it to inform more specifically? Is it to change behaviour? Are there any particularly successful or unsuccessful examples we should be aware of?

41.1
An education and communication strategy should have the following objectives.

- Ensure people understand the alcohol contents of different drinks and have the skill to monitor their own consumption.
- Ensure people know the possible consequences of alcohol consumption and the relationship between patterns of drinking and risk of harm
- Promote attitudes against harmful or excessive drinking which is considered socially undesirable.
- Promote people's belief that they can regulate their own consumption.

NB. These objectives are readily forgotten as the blood alcohol level rises.

41.2
Different approaches are needed to communicate with, for example:

- Younger children (who do not drink)
- Young people
- General adult population
- Adult heavy drinkers
- Adults with alcohol related problems

For the latter two categories see comments about brief interventions etc.

41.3
Outcome criteria to evaluate education and communication might include knowledge and attitudes about alcohol and its effects, and acceptable drinking behaviour.

41.4
Informed choice needs knowledge and skills in the first instance. Justifying possibly more effective interventions (such as price, licensing, and regulation) without prior education would be difficult. Moreover, initial education may assist in the acceptance of regulatory interventions from both social and political points of view.

41.5
Societal attitudes to alcohol are ambiguous. Excessive consumption is both stigmatised and esteemed as an indicator of wealth and conviviality. Clarity is required. Happiness is not dependent on alcohol: alternatively over indulgence is not to be admired but should

attract sympathy. Abstention should be seen as just as acceptable as moderate consumption.

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

42.1
Alcohol education needs to be firmly located and integrated within a curriculum. This holds good at all levels, whether it is schoolchildren, students, or adults. The MCA is striving to ensure that alcohol, retains its position on the curriculum for medical students.
42.2
Within schools education may not be universally effective: it is too simplistic to believe that information so gleaned will prevent all excessive consumption.
42.3
For the general adult population different approaches to schools are necessary. The various skills and techniques of social marketing are required

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

Some confusion arose with the publication of Sensible Drinking which did not accurately tally with the previously published 21/14 units per week message. The alternatives introduced, 3-4, or 2-3 were to say the least unhelpful. Clarity in any future message is essential.

44. How well is scientific research feeding into alcohol education? Is the message based on sound, unbiased and uncontroversial research and are new findings effectively incorporated?

Research needs to be targeted towards certain topics. There are a lot of unknowns e.g. why do only some people who drink excessively develop alcoholic liver disease. On the other hand, socialogical studies produce lots of interesting data but the mechanisms are nor necessarily in place to use that data effectively, e.g., the ESPAD Report 2000 on teenage drinking produced a lot of interest from the media but no formal action resulted. The strategy will hopefully address such issues.

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

Interventions need to be appropriate for their intended audience. Fragmented messages are not necessarily helpful since they tend toundermine overall credibility. Targeting specific groups needs to be donewith care to avoid stigmatisation.

From the MCA perspective there are clear reasons to ensure that health careworkers are in a position to obtain good and reproducible alcoholhistories, and to be able to conduct brief interventions as appropriate. Similarly all medical students need to understand the various ways in whichalcohol can affect health.In this regard the MCA sponsors seminars for medical students as well as producing educative literature. (Ref Medical Students'

Handbook)

Targeting might also be appropriate in the workplace, particularly wherealcohol has potential deleterious affects on performance. Health and Safety regulations may also be at risk in some cases. Some businesses have alcohol policies in place: here again the MCA has produced simple guidelines for small businesses to produce such policies , particularly when such businesses may not have immediate access to occupational health facilities.

Men and women leaving the armed forces may find the transition in culture difficult to tolerate: similarly recently released prisoners may find the tempation of alcohol too great.

Alcohol may be a significant cause of morbidity in the elderly: little research has been done in this group. The increasing numbers of elderly people in the UK make this group an obvious target for more detailed research. Furthermore alcohol may increase their susceptibility to falls with consequential fractures of the neck of femur, Colles fracture of the wrist etc.

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? How can we best establish and preserve a healthy learning environment?

Emphasis is laid on education in schools. However, in isolation such emphasis is unlikely to be totally successful particularly if there is a close relative with an alcohol problem. Alcohol education needs to be integrated within the curriculum (formally and informally). We need to recognise that most pupils live in a world where adults drink and as such children need to be taught responsible drinking: peer pressure is a major challenge in this regard.

47. What role is there for families/parents as role models or in educating their children on sensible levels of alcohol drinking and the risks of alcohol misuse? How can they best be informed and engaged in this effort?

It follows that parents need to ensure their children are introduced to alcohol appropriately: the impact of an alcohol dependent parent on their sons and daughters should not be underestimated. Liaison between parents and schools so that a similar message is being passed is necessary, but this is the same in many aspects of social behaviour.

48. What does experience show on the most effective means of getting messages across? Are there circumstances in which the Government is particularly well placed to do so, or conversely might be particularly unsuccessful?

There is a lot of scope to influence the context of drinking. A good example is the drink/drive message which in general has been successful. That is not to sound complacent because further reduction in alcohol related accidents is always possible. The don't mix drink and and work message has made some progress but again there is room for improvement.

There have been clear changes in attitude to alcohol amongst professional sportsmen: however, alcohol beverage companies still sponsor major sporting events and sports

teams. This anomaly is open to debate. Promotion of a healthy lifestyle is considered desirable: the impact of tobacco, drugs as well as alcohol are well known. At the same time emphasis on the positive affects of responsible drinking, as well as a healthy diet and exercise is necessary. It has to be acknowledged that the final choice is the individual's: however, this choice should be informed.

49. What can we learn from educational initiatives in the field of illegal drugs?

Educational initiatives are not always successful as people may listen but may not heed advice. The message needs to be repeated. Young people are prepared to take risks despite the very well publicised dire consequences of drugs eg Leah Betts.

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

The Portman Group's guidelines on advertising have recently been revised which will hopefully reduce the incidence of inappropriate marketing. Unfortunately differing opinion will not allow total consensus in this debate. The clamour to ban all tobacco advertising is taking a very long time to implement. Any similar proposal to ban all alcohol advertising would almost certainly take even longer.

The cynical introduction of Alcopops by some beverage manufacturers was nothing more than a marketing strategy to attract the young in particular to alcohol, and was certainly successful. Achieving the correct balance between the form of advertising and ultimate profit is very difficult. The beverage industry produces drinks for increasing profits and advertising is there to help achieve this aim. Perhaps the advertisers themselves as well as the beverage companies should subsidise research into alcohol with some of their profits.

The shape of the market and market-based solutions

The drinks industry is a major part of the national economy. It provides large numbers of jobs both in supply and distribution; it influences trends and fashion through its advertising; and it provides a substantial portion of tax revenues. Understanding how that market works, what drives it and how it responds to demand is essential to producing an effective strategy.

Questions

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

This is a response to questions 51 to 55.

The only point to emphasise concerns cost of soft drinks in pubs and restaurants related to question 55.

The hefty mark up of soft drinks in public houses and restaurants is not conducive to overall reduction of alcoholic liquor in such premises. This is a cost disincentive. The industry should be encouraged to develop alternatives to alcohol that provides adequate

commercial return bu not to discourage those such as drivers who have come to the premises to be with friends but do not wish to consume 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? Are there discernible patterns which the Government might use in responding to the effects of alcohol misuse? Is there useful evidence we might draw on?

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

54. How best can Government work with the alcohol industry to reach consumers? What approaches have been shown to be effective in England, the devolved administrations and further afield?

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

The economic costs and benefits of alcohol

Alcohol has significant costs for the economy. It costs the NHS and the police. It costs business money because of lost productivity and in some cases the need to repair alcohol-related damage. And it can be expensive for individuals who drink heavily and may find themselves unable to hold down a job. But it also has benefits. It brings in tax revenue and contributes to GDP. And it contributes to personal and social wellbeing for many. Part of the work on the project will be to form a clear picture of these costs and benefits.

Questions

56. How clear is the evidence both for the wider economic costs and benefits of alcohol? Are there key pieces of research of which we should be aware?

The major difference between alcohol and other drugs including tobacco is that there are positive effects of alcohol on health whereas there are NO beneficial effects of tobacco or drugs. There is a price to pay however, between responsible drinking and over imbibing. The costs to the NHS of treating direct and indirect effects of over indulgence are put somewhere between £500m and £3b a year (Royal College of Physicians report 2001). This cost needs to be weighed against the tax revenue produced by sales of alcohol. A 'cost benefit analysis' might be an interesting exercise.

57. Where are the gaps in the available data on the economic costs and benefits of alcohol? Are there any obvious limitations we should be aware of? Are there any particularly helpful methods for assessing costs and benefits we should be aware of?

This is a response to questions 57 and 58.

Input from all interested parties is required - the costs to the NHS are estimated above.

58. What principles could guide us in deciding who is responsible for costs? How far should they fall to individuals, how far to business and how far to Government?

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

The economic benefits of an alcohol industry primarily relate to the industry as a source of employment - growers, manufacturers, advertisers and marketing, retail sales etc. Health benefits are quite difficult to estimate in financial terms. These benefits are defined in very general terms but are not necessarily well understood by the general population. Similarly alcohol units are not necessarily well understood and hence not well heeded.

60. Alcohol misuse can increase absenteeism and decrease productivity, whilst moderate consumption of alcohol may be beneficial in terms of reducing stress and tension and facilitating networking in the workplace. What in your view are the links between alcohol use and educational and occupational attainment?

The impact of alcohol on absenteeism needs to be more accurately defined. The development of alcohol policies in the work place is a good start, but such policies need to be more obvious for the benefit of the whole of a company's work force. We do not know how frequently hangovers lead to absenteeism. The MCA is frequently asked, particularly in the lead up to Christmas, about the latest hangover cures. The possible impact of the dilution factor never seems to dawn on the various media reporters making the inquiries.

The impact of alcohol on a high profile entertainer or sportsman is widely reported and discussed in the media. Young people are influenced by such people and, whilst in some cases the footballer may benefit in the longer term from the adverse publicity, it would be more beneficial for the majority to encourage a top sportsman without an alcohol problem to preach the benefits of sensible drinking.

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

Alcohol policies within the work place need to be assessed and amended where necessary. The links with occupational health facilities need to be clarified.